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Multiple Impact Therapy
with Families

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Multiple Impact Therapy with Families



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MULTIPLE IMPACT THERAPY WITH FAMILIES

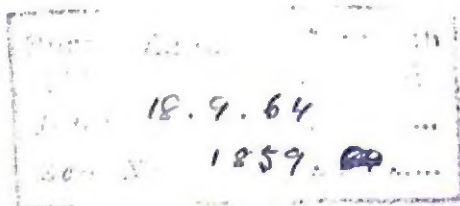
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The project was carried out in the Department of Neurology and Psychiatry of the University of Texas Medical Branch by the Youth Development Project, Eugene C. McDanald, Jr., M.D., Medical Director; Harold A. Goolishian, Ph.D., Administrative Director; Grace K. Jameson, M.D., Supervisor of Psychotherapy; Robert MacGregor, Ph.D., Research Director; Agnes M. Ritchie, M.S.W., Social Worker; Franklin P. Schuster, Jr., M.D., Psychiatrist (1958-1959); Alberto Serrano, M.D., Psychiatrist (1959-1962).

To

TITUS H. HARRIS

Foreword

Follow-up visits at the home 9 months and 18 months later revealed a gradual but marked shift in family balance. The parents supported each other in enforcing standards for Henry's conduct at home, and after staying with relatives across the street for several weeks, Henry returned home at his own request. Evidence of his increased respect for parental authority included his sweeping up and removing fragments of a glass thrown in anger, rather than fighting or running, which had been his habitual response to suggestions that he repair damage he had caused. (Chap. 7, pp. 229-230)

Linda Tague, who seemed to have the task of living out the unexpressed flirtatiousness of her mother, responded with appreciation when her parents enforced rules against her being in unsupervised situations with boys. The bravado of her acting out gave way and she was able to establish solid friendships with the girls her age. . . . When her mother desisted from the patronizing attitude toward her husband, an attitude which made it difficult for Linda to accept him as an authority in the home, Mr. Tague was able to take a more active part in enforcing limits on his daughter's irresponsible but precocious behavior. . . . (Chap. 7, p. 236)

Sally's account of her own impulse control showed her to be growing out of adolescent rebellion. During the follow-up visit she rejected her own plan to spend the summer with the Galveston County friends and was able to return to graduate with her class. (In a later follow-up we learned that instead of being shunned as she had anticipated, Sally enjoyed slightly elevated status among her girl friends.) Diagnostically, Sally had progressed toward maturity. No longer a caricature of her age group, no longer confused by veiled substitutes for parental affection, her heterosexual interests are no longer in the service of rebellion or of gaining peer-group status. She is interested in education, cooperative with authority, and unafraid of her individual identity. (Appendix A, p. 293)

The above glimpses of outcomes of the method called *multiple impact therapy* may not be startling, since movement in role and attitudes within a family can come about without special therapy or through various kinds of therapy. Nevertheless, the ideas in this book are new, impressively so. The method it describes, that of helping a family grow as it confronts the crisis of its adolescent member, is fresh and hopeful. It is far-reaching in its implications for the training of therapists and for behavioral science theorists interested in personality and family interaction.

The authors are refreshingly honest, stolidly scientific, and delightfully enthusiastic. At the same time they check themselves with wholesome candor. They cite negative results. They imply and admit weaknesses among team members. They acknowledge that other approaches to therapy are unshattered by this additional one, different and compelling though it is.

These authors are rightfully enthusiastic. While older approaches rest on their laurels and their jargon, this team therapy idea had to prove itself at every step. To make sure they had something to communicate, the authors delayed publication for three years after the first findings were in. Now their certainty, while less effervescent, is more mature and intriguingly convincing. One critic reader said, "the writing is crisp, clear, and understandable. . . . The authors come to their point quickly, develop their theme extensively, and summarize their results concisely."

What manner of people might want to read what they have to say? Clinicians who note the findings and recommendations of the Joint Commission on Mental Illness and Health are looking for increasingly effective ways to reach the emotional needs of people. Manpower and time are limited, but creativeness and ingenuity are boundless. If the family itself can become a partner in therapy, more energies are released for the task at hand. If team members from various disciplines learn to work together, then the number of therapists on one project is greater and the artificial barriers which separate them lower. If therapy can be shortened in duration with family and community resources enlisted in the

follow-up, more problems can be handled without increasing the number of professional people.

Social scientists may find that they are the principal benefactors from this book. Like many others, they tend to cling to traditions, even though their current "truth" is only a few years old. Granting agencies for research in the behavioral sciences often acknowledge their own bias in favor of neatly designed experiments in human behavior which yield quantified results. The sophisticate in design may be content with his method only to discover that his research treadmill goes nowhere unless he is stimulated by new concepts, new hypotheses, and new formulations about the dynamics of behavior. One of the richest sources for such inventiveness comes from the work of clinicians. Behavioral scientists will find in this book not only the three basic hypotheses listed but also many implications for new social theory. The clinician and the social scientist may find an unexpected congeniality in viewing together this and other new methods. As the therapist schooled in helping the individual allows him to return to the context of his group life and particularly of his family, and as the social scientist studies small groups in action and persons within the group in interaction, the two approaches become, if not kindred, at least complementary.

This book should be used widely by teachers, social workers, ministers, psychiatrists, clinical psychologists, marriage counselors, and especially those who train them all and who ask, How does one best learn to work with people?

INVOLVEMENT

A concept running through many pedagogical approaches in these fields of professional education is the simple but basic one of involvement. The psychoanalyst believes that the budding psychiatrist will learn increasingly about working with others after he has discovered more about himself. The Human Relations Training Laboratory stresses involvement, using the theory that only as the members of a training group become sensitized to the roles which they and others are playing in the group can they gain in-

sight and skill in group process and leadership. Ministers, teachers, and social workers become involved at an earlier stage in their training in actual field work. With a supervisor or trainer near at hand, each exposure to real problems becomes a learning experience. Supervision develops the personal skills. Seminars draw out the theory.

Against the background of the above approaches to professional education, we can say that multiple impact therapy provides a type of training with a double advantage. Each member of the therapy team and the family becomes involved at the outset in a realistic way. The adolescent is seated in the room with the other family and team members. In a compelling way, he personifies the crisis which caused the family to seek help.

There is a second kind of involvement here which is sometimes missing in other professional pedagogy. The members of the team, including a trainee or two who may be present, try to set the model for frank and probing analysis of the problem and of one another's views of it. They, as well as the family, subject themselves to confrontation. The family learns to meet conflict within itself by observing how mature members of a therapy team can keep face while they disagree with and even criticize one another during the prolonged sessions. The professionals in training who join the team find that this is an experience of high learning value to them as well.

FLEXIBILITY

Members of the team who have produced this book out of four years of experimentation have avoided the danger of creating a new orthodoxy. Sometimes their method fails; at other times it prepares the way for different forms of therapy. And the "method" itself is constantly undergoing change. Flexibility of pattern is a principal characteristic. The basic notion allows for all manner of variation. The time element does limit this type of intensive therapy to two or three days of almost uninterrupted conferences

of one type or another. To free a therapy team to work so continuously with one family takes some doing. When therapy is over, the family is on its way, relying for help on its newly discovered inner resources, knowing more where to turn in its own community, and feeling welcome to request a follow-up conference with the team.

THE TEAM MEMBERS

A description of the special roles played by the different members of the team, all from The University of Texas Medical Branch, will give the reader a closer view of the collaboration of the authors.

EUGENE C. McDANALD, JR., M.D., *Project Co-Director, Associate Professor in the Department of Neurology and Psychiatry.*

Dr. McDanald played an important role in formulating the program, in preparing the research proposals, and in editing the manuscript. He helped correlate the project with the other activities of the Department of Psychiatry and of the Medical Branch. His guidance of the process of collaboration created an atmosphere in which people from different disciplines could work with optimum effectiveness. From the background of his earlier experience as Medical Director of the Youth Development Project, Dr. McDanald was able to introduce clinical research into the treatment of adolescents. He examined every innovation in the project plan for its clinical and theoretical soundness. From him came suggestions for many of the therapeutic operations and diagnostic formulations. In the actual team process, Dr. McDanald was usually the principal psychiatric consultant at the session which was held the second day of therapy. He was aided in this role by Dr. Grace Jameson, co-worker in the Department of Psychiatry.

HAROLD A. GOOLISHIAN, PH.D., *Project Co-Director, Associate Professor and Director, Division of Psychology, Department of Neurology and Psychiatry.*

Dr. Goolishian served as Administrative Director of the Youth Development Project. With Dr. McDonald and the staff, he envisaged the need for a brief family-centered therapy capitalizing on the rapidity of change possible in the adolescent years. He brought to the experimental stage of development many techniques of the group therapist. A particular innovation in which he collaborated was that of debating with a co-therapist in the presence of the adolescent so as to bring the youngster to clarify his own position. Dr. Goolishian helped clinically throughout the period during which the present methods were developed. He was adept at bringing the therapist-in-training into comfortable participation with a method of therapy new to the trainee. When the basic team of the project was enlarged with a staff psychiatrist, his role became the more supervisory and administrative one of leading clinical and theoretical discussions and of making it possible for the team to work at the clinical and research level without administrative and service duties.

ROBERT MACGREGOR, PH.D., *Project Research Director, Assistant Professor (Psychology) in the Department of Neurology and Psychiatry.*

Dr. MacGregor attempted to bring together in a repeatable way as many of the ingredients in the intake, inception of treatment, and supervision processes as seemed to account for the evidence that the important changes in therapy often happen early. His work included recognizing and organizing into a sequence some well-developed talents of the other team members. He stressed the relation of interpersonal theory to interpersonal therapeutic operations. With Dr. Schuster, he helped develop a division-of-labor view of family defenses for use as a diagnostic device. As Research Director of the Project, his was the task of organizing the analysis of data, and he had major responsibility for the writing of this book. In the therapeutic procedure, his role was that of (1) analyzing the group dynamic situation confronting the family and therapists, and (2) monitoring the timing of group and other inter-

view situations so that the experiment was as nearly as possible replicated in each case insofar as the team's clinical judgment did not call for altering it.

AGNES M. RITCHIE, M.S.W., *Social Worker, Instructor (Social Work) in the Department of Neurology and Psychiatry.*

The special ability of Mrs. Ritchie to give a colleague a concise, interpretive report on an interview in the presence of the person interviewed provided the way of sewing this therapy together. In all phases of the project she was the one to keep the research based on the actual data of the families. She found it necessary at times to be quite active in holding the team members' feet on the ground by use of her well-disciplined skill in keeping reality factors in the family within the awareness of the team. Her ability to remain clear-headed in matters of role and function is evidenced where this matter of role of each of the treatment-team members is described in detail.

FRANKLIN P. SCHUSTER, JR., M.D., *Psychiatrist, Instructor in the Department of Neurology and Psychiatry (1958-1959).*

In his participation in the development of techniques of therapy and of methods of evaluation of data, Dr. Schuster brought with him a fourfold scheme for study of immaturity reactions. His principal contribution, however, was his ability to report case material in a vivid way in spite of the constraint of analytical categories. His effort to treat each case as a fresh new experiment calling for the development of new techniques was often in useful counterpoint to the Research Director's desire to replicate as much as possible. From such controversy the project grew.

ALBERTO C. SERRANO, M.D., *Psychiatrist, Instructor in the Department of Neurology and Psychiatry, 1959-1962.*

Dr. Serrano gave final direction to the role of the psychiatrist on the MIT team. He had a major hand in relating the division-of-function view of family interactional processes to the develop-

mental schema. He participated in the content preparation for various chapters of the final report. He continued to see new families, to train new teams in the method, and to check theories against later evidence. In his work with the therapeutic team, he was often the member to see the young person and to take initiative in planning an active role for the child in the family therapy.

ROBERT L. SUTHERLAND, *Director,*
The Hogg Foundation for Mental Health,
The University of Texas, Austin, Texas

Preface

This book reports on a six-year study by the family psychotherapy research staff at The University of Texas Medical Branch and describes a new type of brief, intensive psychotherapy—*multiple impact therapy*—for families with disturbed adolescents. It has been written for readers with a professional and theoretical interest in family dynamics and therapy. Among those who have expressed special concern that our studies be presented in detail have been guest therapists and observers of various disciplines: psychoanalytic and eclectic psychiatrists, clinical and research psychologists, social workers, sociologists, ministers, school counselors, and probation officers.

Our idea of intensive short-term family therapy was conceived in 1956 when it was noted that many parents were unable to participate with their son or daughter in the conventional treatment program because of time, distance, and economic factors that precluded regular visits to the clinic. The research staff thought, after experimenting with different approaches, that these obstacles might be removed and that family self-rehabilitative processes might be mobilized if arrangements could be made for the adolescent, his parents, and other significant members of the family and community to meet for two days of intensive therapy with a multidisciplinary psychotherapy team of one or more psychiatrists, psychologists, and social workers.

Three central ideas and certain standard procedures have guided the team's efforts to achieve therapeutic impact in team-family and individual sessions. The ideas are:

Recognizable patterns of parental interaction are apt to produce and maintain in dynamic equilibrium specific forms of developmental arrest in offspring which issue in various types of behavioral maladjustment in adolescence. As a result of viewing disturbed adolescent behavior from a familial interactional frame of reference, we have described four types of maladjustment reaction of adolescence—infantile (schizophrenic reaction), childish (near-psychopathic or near-psychotic reaction), juvenile (neurotic reaction), and preadolescent (personality disorder)—which can be correlated with rather specific modes of parental interaction. We have also found that the therapeutic goal for each family is more or less determined by the nature of the arresting forces in the parents and the stage of developmental arrest with its corresponding personality excess or deficit in the adolescent.

Certain types of interaction of the team with itself and the family in crisis may serve as model behavior with which the family may identify in its problem-solving efforts. In its model role, the team has striven to behave in a manner opposite to that of a sick family: it tries to be self-conscious in its personal impact on the family, spontaneous in its self-criticism and self-correction, open to all points of view but incisive in its expression of what appears to be of value, earnest and good-humored in debate, and firm but kindly in its confrontation of itself and the family with significant issues. The integrity of the team in dealing with itself in the presence of the family came to be viewed as a *sine qua non* in mobilizing the family to become more objective and insightful about its own interactions. The team discovered early in its work that if it dealt with itself matter-of-factly and good humoredly, the family would accept the same type of approach from the team, even when the team presented it with the most jarring facts. The team's interaction with the family differs from the conventional individual, group, and family therapy models in that it communicates about the communication process by extended example, thereby making concrete the give-and-take process that promotes

recognition and resolution of interpersonal or intrafamilial difficulties.

Certain messages of respect from the team to the family concerning the family's predicament and capacity for change may have favorable impact on the family's self-evaluative and self-revisory functions (family self-rehabilitative processes). The team communicates its respect for cause-and-effect relationships by pointing up in the initial team-family conference and in individual sessions that the offending behavior in the adolescent is relevant to the circumstances encountered in the home and community. Each therapist communicates respect for the particular family member he sees initially in individual session by inviting him to explain his side of the family crisis. Respect for the sense that is made of intrafamilial behavior or attitude in private sessions is communicated by sharing this information with the pertinent family member in joint or team-family sessions. Respect for the assets or the dormant potential of the adolescent and the overlooked worthwhile aspects of the spouses that are discovered in individual sessions is communicated by the therapists to the appropriate family members in joint sessions. In the final closing session, the team respectfully challenges the family members by emphasizing that the insights which may have been gained in the two days of therapy will have no value unless each dares to implement them through developing new and more meaningful patterns of relating. (The development is frequently well under way before the two-day period is completed.)

The specific types of therapeutic activity implementing these ideas blend in with the conventional investigative and therapeutic procedures which are part and parcel of the team's therapeutic armamentarium. As a matter of fact, the therapeutic activities predicated on our hypotheses would not be carried on in a context having therapeutic impact if the team did not use them in conjunction with such basic operations as securing pertinent life-history material, making and revising formulations of individual

and family dynamics, observing and interpreting the realistic and transference reactions of the family to the team, using counter-transference awareness to check irrational responses to the family, recognizing the realistic reactions to a family as a basis for meaningful confrontation, reviewing and summarizing data, defining interpersonal problems, and working on and through these problems until there is an awareness of how the family relationships might be favorably altered.

Therapeutic results indicate that multiple impact therapy, though by no means employed in each instance as a definitive form of treatment, succeeds in by far the majority of instances in mobilizing healthy interpersonal processes within the family. It is the method of choice for initiating therapy when a family crisis exists; it is also the method of choice for creating a salutary crisis within a family in treatment where an intrafamilial stalemate exists. It is suited for families with adolescents difficult to involve in individual psychotherapy, and especially for families with childish adolescents, the latter being notoriously refractory to conventional forms of therapy. Because follow-up studies indicate that multiple impact therapy has achieved an unusual degree of success with neurotic and schizophrenic adolescents, it would appear to be a very promising method for defining the family interaction that produces neurotic and schizophrenic disturbances in adolescents and for enabling the family as a whole to work out healthier patterns of relating. Our procedures also brought about a favorable outcome in the majority of adolescents who presented personality disorders centering around the need to rebel against responsibility and to claim special privileges.

There are no known contraindications to multiple impact therapy. It is not to be used, however, for minor problems known to respond to procedures that demand less clinic time. What may preclude its use in certain instances is the inability of a heavily encumbered clinic or family to set aside the time that multiple impact therapy requires.

The strength of multiple impact therapy rests on several facts:

The team serves as a model of healthy group functioning. The family interaction with itself and the team provides cumulative and converging data which the team constantly has on view and utilizes as it works with the family to define and resolve issues. Evasion of an issue is difficult in a setting where one or more team or family members show a readiness to deal with the issue. Channels of communication are easier to keep open in view of the number of participants who feel they have a stake in keeping meaningful discussion going. Protective interventions by the team on behalf of family members under attack render the attack and its sometimes jarring insight bearable. The family members are gradually prepared for changes in each other without loss of face. Insights that are acted on in the presence of the family while treatment is in progress serve as a stimulus to family members to alter their stereotyped responses to the person who is changing. The team-family rapport at the conclusion of therapy is an important dynamic force in the homework the family does on its problems in the interval between returning home and the time of the follow-up program.

Another strength of multiple impact therapy is in its utilization of the creative capacity of a professional group to develop theories about behavior which adequately encompass what has been observed.

The weakness of multiple impact therapy is the inherent weakness in all psychotherapies: it takes time to formulate dynamics and therapeutic strategy and, in the case of multiple impact therapy, between half a day and a whole day is dedicated to amassing data that the team can individually and collectively utilize.

There are applications and uses of multiple impact therapy other than those mentioned. It has been valuable in informing members of the family's community—ministers, probation officers, school counselors, and nurses—on our mode of evaluating and treating families, and in helping such people to define more meaningfully the approach to their special responsibility to the family. One-day multiple impact therapy procedures have been useful in helping

a family to accept therapy for one of its members, and in providing diagnostic studies and treatment recommendations on families handled by distant agencies. Multiple impact therapy is well suited as a training medium in family dynamics and therapy for medical students, social workers, psychological interns, psychiatric residents, and practicing professionals. For the beginner in psychotherapy, it provides an insightful overview into the problems of adults and adolescents which he will encounter later in his individual psychotherapy training. For the professional, to quote one of our visiting colleagues, "It provides an approach that is refreshingly different." For any team, even an experienced one, multiple impact therapy provides the continuous type of in-service training inherent in a new and creative therapeutic approach.

The research staff realizes that it is impossible to express the full measure of gratitude it owes to its sponsors, consultants, and guest therapists. To the Hogg Foundation for Mental Health we owe our start. To the National Institutes of Health we owe our continuance. Dr. Titus Harris provided an experimental climate conducive to research. Dr. Grace Jameson contributed many hours of valuable clinical help. Dr. Florence Powdermaker stimulated the staff to think through its research data. Dr. Martin Grotjahn provided new perspectives on our therapeutic operations. Dr. Robert B. White rendered invaluable editorial help during the critical period of revising our initial draft. In Mrs. Sidney Smith we found a patient friend and tutor who helped in the rewriting of several sections of this manuscript.

EUGENE C. McDANALD, JR., M.D.
HAROLD A. GOOLISHIAN, Ph.D.
Co-Directors

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CHAPTER I

The Development of a Family Therapy

Family therapy is a radically new approach to mental illness and yet an old one. For years family physicians, family service agencies, and pastoral counselors have worked toward evoking the natural growth-enhancing processes in families. Psychiatrists have known that the continued rehabilitation of the patient who returns from the hospital to his family unit often depends on improvement in the situation which contributed to his becoming a patient. Toward this end they have counseled the family, collaborated with social workers in extending casework and psychotherapy into the home and community, brought relatives into the hospital's group therapy program, used psychodrama to help the patient experience back-home problems before he meets them; and more recently they have tried bringing whole families into the hospital for psychotherapy.

In outpatient settings the tradition of collaboration between disciplines of psychiatry, psychology, social work, and public health nursing growing out of the child guidance clinic movement has laid such a firm groundwork for the new family therapies that authors of a recent survey of the field could find almost no adverse

criticism of its mushrooming methodology [1].* As a natural outgrowth of sophisticated methods, family therapy has had some difficulty in fully exploiting the therapeutic media which the presence of the family make available, just as television imitated radio for too long before its own dimensions were appreciated.

The attitude of therapists and clinical researchers toward teams has had a history that parallels their attitude toward the family. Just as psychotherapy is getting over its resistance to the therapist coming into contact with members of the family, therapeutic teams are becoming able to use information from their own interaction for the benefit of the patient. Everyone believed in teamwork, but it lacked the intended togetherness. Bronfenbrenner [2] among others reported on the rigors and rewards of surviving the stages of development of an interdisciplinary research team. Johnson [3] points out the difficulties in communication between co-therapists on interdisciplinary clinic teams. Starr [4], representing the attitude of the child guidance clinic movement, concluded that the alternatives were (1) individual therapy by separate therapists working in isolation with each family member and (2) a single therapist working with the mother and the child in that order. Study of the interaction of professional people involved to understand the patient better, as it has appeared in milieu therapy, multiple therapy, and the simultaneous treatment of marital partners by therapists who together consult a third therapist, has led to a renewed interest in the possibility of team therapy [5]. In developing conjoint family therapy, Don D. Jackson [6] and his co-workers at Palo Alto not only have brought the team and family together but have worked seriously in the area of communications research to understand as well as reduce the interprofessional communication problem.

The present report is that of a demonstration project in family therapy which departs from the once-a-week format of other outpatient family therapies and attempts to work in dimensions of the

* Numbers in brackets refer to Appendix B, Chapter Notes, including bibliographical citations.

cumulative impact and convergence of different views that are separately developed by varying combinations of the family members and mental health specialists within a two-day period. The purpose of our research had been to develop a brief therapy appropriate to certain problems arising in families of adolescents, to improve methods of identifying these cases, and to evaluate clinical results of treatment. The method consisted of a series of contacts focused preferably in a two-day intensive work-up of the adolescent patient and significant people from his community. The team has regarded contemporary issues in the family's life as the painful or pathogenic events which have enhanced readiness for meaningful changes [7].

The Youth Development Project from which the present report originated was an outpatient clinic organized in 1952 for the study and treatment of problems of adolescents and their families by representatives of several disciplines in the medical and behavioral sciences. From its inception it sought to take advantage of the rapidity of behavioral change observed to occur during adolescent years. Not only did we observe that these youngsters, who during preadolescence and adolescence are naturally in a period of rapid personality integration, were accessible to briefer psychotherapeutic influence, but also we observed that their families, perhaps because of the crises precipitated by the youthful members, were amenable to change. We found, as did Caplan [8], that the amount of intervention may be usefully kept to a minimum when the need for change is strongly felt by the family. The staff of the Youth Development Project began to evolve a therapy which exposes the family to awareness of the dynamics of its problems in an atmosphere which permits change. While the longer procedures of working through problems until insights are achieved may occur at home later or may be utilized in attenuated form during family therapy sessions, our approach in general does not follow the conventional psychoanalytic model.

However, like analytical and group-analytical therapies, its goal is more to evoke health than to suppress what seems undesirable.

We differ from Frank's [9] rationale about how evocative therapies work in that the persuasive effort goes into demonstrating the therapists' confidence in the self-rehabilitative potential of the family more than into developing the patient's faith in the doctor.

A pilot study on a dozen families was conducted during 1957 to test the feasibility of an intensive, family-oriented, brief psychotherapeutic method. It had been observed by this staff and by others that the human encounters involved at the inception of therapy, including the feeling of commitment to a constructive endeavor, may be the most therapeutic of experiences. The procedures used in the pilot year, which later became incorporated into *multiple impact therapy* (MIT), were at first an expansion of clinic intake procedures. Colleagues and supervisors were brought into these initial sessions so that the patient and family could benefit from the kind of healthy group processes, review, and discussion of relevant dynamics that go on between colleagues. Early in these team-family contacts the staff communicated to the family a theory concerning psychopathology and therapy. This was conveyed by our attitude that treatment is really not under way until the behavior complained of in the nominal patient is seen as understandable strategy for dealing with the family or other situations under the circumstances they describe. These procedures led the family members to have a much clearer idea of what the team needed to know about their problems. Other ways were developed to enlist the family in a project which appeared to them in the beginning as diagnostic but which was perceived later on as the mobilization of self-rehabilitative efforts.

MULTIPLE IMPACT THERAPY

The intake process in MIT includes various team-family contacts which, when possible, start and end with a team-family conference. Between these two group sessions, an hour is used for individual sessions or multiple-therapist situations during which the possibility of a later two-day workshop approach to the difficulties is explored.

Before MIT sessions are initiated with any family, the clinic team meets together and reviews all available referral information. This material may have been forwarded by the referring agency or it may be the data from the group-intake sessions with the Youth Project staff. At these preliminary staff conferences the team explores hypotheses about the family and its potential. Freedom to speculate is encouraged so that the team members in this encounter become known to each other by their ways of thought concerning the available material.

In contrast to the usual child guidance clinic schedule, in this psychotherapy the treatment team including psychiatrist, psychologist, and social worker undertakes to work with one family group for a full two to three days. During this time the team works with the family for a period of six to eight hours each day. At the conclusion of this time, the family is discharged after arrangements are made for appropriate follow-up studies, which may be as frequent as one in each month for the first six months, or one at six months and one a year later as required by our research.

The family to be seen arrives at the clinic at 9:30 in the morning and is invited into the first team-family conference. The family generally includes those living in the household—both parents, the adolescent, siblings, at times grandparents or other relatives living in the home. The work occasionally includes community representatives such as probation officers, family service workers, or clergymen.

The interviewing procedures used are varied and flexible, consisting essentially of an initial team-family conference followed by a series of individual interviews, joint interviews (two patients with one or more therapists, or one therapist with two or more patients), and overlapping interviews (where the therapist who terminates an interview early joins in the interview with another therapist). These procedures may be interrupted by formal and informal team or family conferences. By such overlapping the team first makes some temporary bridges over broken channels of communication and, by becoming for a while a part of the family group, gives the

family some experience in functioning as a more receptive system.

The initial conference includes both team and family and lasts approximately one hour. After general introductions the members of the family are invited to outline in their own words the nature of the immediate crisis and their views regarding what they feel to be the core of their difficulties. Almost invariably one person acts as spokesman for the family group and the participation of the others must be encouraged and supported. In these initial conferences gross patterns of family interaction and established patterns of communication become evident. Most families are unaccustomed to this novel interchange and experience a rapid build-up of tension and discomfort. Release of tension is provided toward the end of the hour when the therapists invite each of the family to an individual interview. We have found it useful to tell the family how team members happened to select the particular family member to be seen, and we are ready to discuss openly the reason for any procedures when they occur.

During the first morning the overlapping interviews begin to play an important therapeutic role. This technique is designed to help facilitate communication within the family. Part-way through an individual interview one team member telephones another and asks for permission to join the session. The therapist whose office he enters summarizes the interview to that point, makes interpretations, clarifies and restates issues, and points up tentative conclusions. The patient is invited to participate in this recapitulation and to make needed corrections. The second therapist responds to this summary by reflecting its possible meaning in the life of family members he has interviewed. Long-standing barriers to communications and resistances to insight often disappear during these overlapping interviews.

Following the individual interviews and overlapping sessions it is ordinarily time for lunch and the clinic staff meet for case conference with consultants. During this meeting the collaborators propose working formulations concerning the role of various mem-

bers of the family in its dynamic equilibrium. Tentative treatment plans and the afternoon's schedule are arranged.

Following the staff conference and the completion of these preliminary diagnostic formulations the afternoon work begins. At this time the adolescent in the family is usually given the battery of psychological tests. The team member who has seen one parent in the morning now sees the other parent. From the afternoon of the first day on, overlapping and multiple interviews become quite frequent and continue to play an important therapeutic role. Within this over-all procedure there is considerable room for variations appropriate to the family's dynamics and the pathological condition of any one person. By the afternoon of the first day the family has usually developed an appreciation of what the current crisis is about, problem areas have been identified, and areas of unrealized potential for emotional growth have begun to appear. Family discomfort in many cases has been increased because barriers to communication maintained by collusion among some members of the family could no longer be invoked without some awareness of their divisive force. Often there are spontaneous family discussions.

Local families go home for the night, while families from out of town usually find hotel or other lodgings near the medical center. The team does not arrange or recommend accommodations.

The second day begins with a brief team-family conference followed by individual and joint sessions. The result of family discussions of the previous evening, or in some instances the lack of results, is typically the immediate content of the first team-family conference of the second day. Suggestions as to future plans and forgotten historical material are often supplied at this time by the family. This new information is enlarged upon and its significance explored in subsequent individual and multiple-therapy sessions. On the afternoon of the final day the content of the various interviews begins to be directed by the family's concern toward its immediate and anticipated back-home problems. Each of the fam-

ily members is encouraged to criticize and formulate the emerging view of family life from his own point of view. Overlapping interviews with continuing recombinations of family and team members are most important during this last afternoon in order to facilitate psychotherapeutic convergence. This movement does not stop until a high degree of understanding and resolution is reached. The final afternoon ends with a team-family conference in which much of the preceding therapeutic work and unresolved issues are recapitulated. The family is assured of the team's continuing interest as they plan together both follow-up visits and what to do when expected recurrences of family difficulties appear. The team assures the family that neurotic and distorted interpersonal orientations do not disappear overnight, but rather that the family members, through their own continuing self-revisory functions, can change in their way of relating to each other. This change, the team advises them, will alter the balance of forces in the family and may stimulate one of them to test the durability of the change. We invite them to take special note of how they deal with such test crises. It is our view that patterns brought into awareness in therapy contribute to therapeutic movement at home. How the family handled such situations, then, is the immediate material at follow-up sessions whether they are held in the family home or in the clinic. The follow-up procedures are similar to those used at intake.

FAMILY DYNAMICS AND THERAPY

We share with many others in the new field of family therapy the impression that individuals can handle in family-like groups emotional material that would be quite devastating without the presence of familiars. This was in part the lesson from the military psychiatrists who found that men who became psychiatric casualties could be rehabilitated in their regular units. They found that men with similar problems did not regularly respond to treatment when they were removed from the units in which they had a feeling of membership.

In the theoretical consideration of the problem with which we deal in family therapy we disagree somewhat with the notion that the roles and illnesses in families can be comprehended by the model of homeostasis. This model has given rise to useful, dynamic understanding of defensive or neurotic functioning as illustrated by such concepts as the marital skew of Lidz, Cornelison, Fleck, and Terry [10]; the family homeostasis of Don Jackson [11]; and the pseudomutuality described in the work of Wynne, Ryckoff, Day, and Hirsch [12]. We find that the model does not embrace the aspects of growth that have to do with emergence from the family matrix; nor does it adequately cover the therapeutic mobilization of self-rehabilitative processes, which is better accommodated in Bertalanffy's [13] view that the human organism is an open system characterized by a steady state which maintains its own creative tensions.

To mobilize family self-rehabilitative processes MIT has developed a format that differs from the family therapy of John E. Bell [14] and Nathan Ackerman [15]. These two pioneers in outpatient family therapy have carried over from group therapy a schedule of weekly or more frequent sessions of one or two hours duration. Our method, in contrast, involves the cumulative effect of work concentrated in two full days where there are various combinations of individual and multiple-therapist situations which reach convergence in family conferences. Periods between family-team contacts in MIT are significantly longer than in the conventionally scheduled therapy sessions.

MIT incorporated into its approach ideas about family dynamics, the influence of the therapist and the method, and the way in which therapeutic intervention evokes health. Concerning family dynamics and psychopathology, we thought the behavior of the adolescent patient as a family problem could be shown to be an expression of an arrest in development at a level beyond which the family could not foster development. The arresting forces in the family seem to issue from mutually exploitative relationships which limit communication and force each family member into repetitive

roles incompatible with growth. Concerning the way in which the therapeutic team influences behavior, we thought the team might temporarily interrupt the arresting forces in the family by participating in family communications as a healthy model of interpersonal interaction which showed particular respect for the family's problems and defenses. Concerning growth toward health, we thought that the growth potential of family members, when enhanced by awareness and understanding of their recurring difficulties, would yield further improvement during extended periods of living without therapeutic supervision. Research with MIT has given support to this frame of reference.

EVALUATION

The evaluative part of our research was aimed at determining whether changes in the families and the adolescents could be attributed to the therapeutic method, whether the cases for which it is suitable represent a significant proportion of the emotional disturbances in adolescence, and whether there were some types of problems for which MIT is better suited than others.

Because no scientifically acceptable quantitative methods have been developed in the field of research into the outcome of psychotherapy [16], we have placed our main emphasis on thorough description of our work with each family and have supplemented this by ample recording. Sixty-two families with emotionally disturbed adolescents were treated with MIT by the investigators during a three-year period and have been followed regularly in home or clinic visits. The team regulated intake by accepting only those patients who came from intact families and by insisting that the population studied have variety in regard to ethnic, socioeconomic, and psychiatric problems. We decided to test the method by exposing it to the more severe adolescent psychiatric problems of all types. All were cases in which institutionalization, family breakup, or other expulsion from the home community was imminent. Such a test, we felt, would indicate whether the method is a treatment

suited to a few cases or whether it is a psychotherapy applicable to typical severe adolescent-family problems.

To ensure consistency in comparing families with other families and in reevaluating these families, the data from intake, the two-day work, and the follow-up were dictated according to an a priori outline of significant areas of family living. The assembled team dictated the material together after dictating a session-by-session account of the work. From these data the investigators empirically developed a research outline in the second and third years by studying recurring patterns found in the dictated data. The patterns were arranged at first in what appeared to be an order of "severity." This was soon perceived to be a developmental scale. Classifying and rating of our data according to this a posteriori outline showed that the developmental criteria could be used to identify types of adolescents according to recurring behavior patterns, and to identify their families.

It was the data on therapeutic movement that led us to depart from an earlier field-of-forces schema. Change did not usually occur as movement up straight-line scales or from one arrest in development to another, but as a departure from a relatively closed system of neurotic checks and balances into a relatively open system of freer communication and accessibility to life's challenges. As had other investigators [17], we had illustrated family emotional functioning graphically on a fourfold chart included in the research outline. This was designed to illustrate immature ways of responding to stress. The quadrants of the chart reflected the immaturity reactions described in standard nomenclature: aggressive, passive-aggressive, passive-dependent, and emotionally unstable. In this field of forces we could chart only sick behavior. In order to reflect therapeutic movement in family members, we added to the center of the fourfold chart a circle to indicate a general area of more creative living (Fig. 1-1).

Follow-up studies revealed that in the 62 families treated by multiple impact therapy procedures, there was significant improve-

ment in 49 of the adolescents. All six adolescents classified by our developmental criteria as *infantile functioning in adolescence* (schizophrenic reactions) showed distinct improvement in their ability to cope with problems realistically. Of the 22 youngsters diagnosed as *childish functioning in adolescence* (near-psychopathic and near-psychotic reactions), 14 exhibited a surprising degree of favorable change in their interpersonal relatedness. All of the 14 cases diagnosed as *juvenile functioning in adolescence* (neurotic reactions) demonstrated a marked dropout of neurotic tendencies. Of 20 diagnosed as *preadolescent functioning in adolescence* (personality disorders), 15 showed considerable improvement in their ability to handle responsibility and relate intimately.

Thus, we found that we were dealing with a representative group of emotional disturbances in adolescence ranging from schizophrenia through the neuroses and personality disorders. Strongest support for the validity of the method came in part from comparing data on recurring patterns of therapeutic activity employed by the team with the data on family patterns. This showed that MIT is a psychotherapy with varying strategies suitable to a variety of specific problems in adolescent-family relations. The results of therapy indicate that MIT is particularly suited to pathological conditions where it has been difficult in conventional therapies to enlist the patient and other family members into a psychotherapeutic pro-



FIG. 1-1. Family Constellation Chart illustrates family interaction. The four quadrants represent immaturity reactions; their relatively healthy counterparts are indicated as moving toward or into the center circle of healthy interaction and growth.

gram. It also provides certain advantages in the treatment of neuroses where other methods are also effective.

As a way of studying the operation of family and team processes by participant, cross-monitored observation, the method has yielded some promising observations for further investigation. Attitudes of dysphoria and of enthusiasm, for example, seem to rotate among family members in a way that may be used to predict which family member other than the nominal patient may become an identified patient requiring special help or may become a particularly strong resource in the family. Normally a similar rotating process was present in the team. When it was not present, that fact proved useful as a signal to look for the possibility that the team might be unwittingly collaborating to shield itself from the real facts about the family.

The advantages of MIT in bringing supervisors closer to trainees and in staff development through improved team collaboration were unexpected findings. MIT, indeed, has an effect on teams not unlike its effect on families.

CHAPTER 2

Illustration of the Method

This chapter presents a report on multiple impact therapy with a family from referral through intake, treatment, and follow-up. Excerpts from the typescript of tape recordings supplement and illustrate description of the work.

THE JONES FAMILY

The Jones family included Mr. and Mrs. Jones and their two sons, Peter and Paul. Peter, the manifest patient, was 15 years old and Paul was age 9. Mr. Jones was a competent and well-liked sales manager for a small oil company. In contrast, at home Mrs. Jones was the competent "manager," who assumed full responsibility for the rearing of the children, although she occasionally delegated disciplinary duties to her husband. He nursed considerable resentment against his wife because of her possessive and controlling attitude toward him and the two boys. He attempted to buy Peter's affection, on one occasion purchasing for him a motor scooter in spite of his wife's strenuous objection.

Peter was a well-built, muscular boy with broad shoulders, about average height for his 15 years. During early childhood he had suffered severely from asthma that occasionally recurred during adolescence. Since puberty he had presented alarming behavior

problems including truancy from school, several runaways, belligerent threatening against both parents, fighting, and general disregard for authority. The probation officer reported that the mother had lived in fear of the boy's violence for the past year. He had threatened her with a crowbar recently and a year ago had challenged his father with a switchblade knife, asking the father to fight so he could cut him. Some of his fights were precipitated by derogatory comments made by other boys about girls Peter dated. Although of bright normal intelligence, he had done failing work in the last year of junior high school.

Peter's first appearance in juvenile court was brought about when he heard a rumor that a boy was planning to rape his girl friend and he rushed to her defense in his mother's car, having forcibly taken the car keys from his mother. A date was set for Peter to appear in court, and the judge admonished the boy to "stay out of trouble" until the scheduled hearing. A few days later Peter ran away with the same girl, ostensibly to protect her since he was unable to persuade her not to run away from home. On this occasion he left during the night in a company car his father had parked in the driveway, and, as she had on the previous occasion, his mother notified the police. The following day Peter was arrested in a town about 300 miles away, after he drove out of a filling station without paying for a tankful of gasoline. On being identified as runaways, Peter and the girl were returned to their own county and Peter was promptly committed to the state training school. There he adjusted well, but when he was released on parole six months later, he was soon in trouble again for truancy and fighting.

Nine-year-old Paul was also severely maladjusted. An extremely infantile, anxious, and dependent youngster, he was unable to tell time, to dress himself, to tie his shoelaces, or even to go to the bathroom alone. His scholastic performance in the third grade was very poor, and he required so much help with his homework assignments that his mother suspected that Paul might be mentally retarded. However, psychological tests indicated that Paul was of above average intelligence.

Referral

Peter Jones was referred to the University of Texas Medical Branch Hospital in Galveston by the family physician who had treated Peter for asthma in earlier years. It seemed likely that his unruly behavior might result in his being returned to the state training school where he had already served several months. An earlier attempt at individual psychotherapy by a local psychologist had failed because of Peter's refusal to cooperate; this was just prior to his appearance in juvenile court and commitment to the state training school.

Peter adjusted well in the hospital as he had to the highly structured regime of the state training school. The hospital psychiatrists recognized his compliance with authority as superficial, and they regarded the episodes of impulsive, antisocial behavior as a preschizophrenic kind of acting out.

Because Peter's problems seemed to be only one manifestation of a severely disturbed family, Peter and his family were referred by the hospital physician for multiple impact therapy. The intake conference with the patient and family was held on the date of Peter's discharge from the hospital.

Intake Conference

Peter and his family were introduced to the research team by Dr. Y., the psychiatry resident who had worked with Peter in the hospital. During the opening family-team conference Peter was cool, composed, arrogant, and belligerent. He attempted to show from the first that he was "in charge" of the situation. Indeed, as far as he was concerned, the family had come on his terms. In fact, after the date was set by the doctors for the conference with Peter's family, he had telephoned them long-distance to say that if they did not come on the selected day, he would run away or kill himself. At the team-family conference Peter made it clear to the team that all he wanted from them was a minimum of interference in his plan of getting a replacement for his motor scooter that his father

had sold while Peter was in the training school. The father appeared ingratiating, and did not seem accustomed to having his views taken seriously in family matters. At first, he responded to his son in a cajoling way in an attempt to vindicate himself for having sold Peter's motor scooter. The mother, a well-dressed, attractive, but tired-looking person, seemed cold and sometimes was sarcastic. She unwittingly joined in her son's attack on his father in her attempt to promise a future automobile instead of a scooter. The boy brought them into line by saying, "Then I'll get myself sent back to reform school and who will be sorry?" A team member called attention to the despair implied by the self-defeating maneuvers, and the underlying depression in his threats to influence them by his death or absence.

Nine-year-old Paul responded to the lack of parental leadership by showing off in the group with comments that echoed his mother's derogatory opinions about family members, such as "Daddy drives too fast," and "Peter won't listen." Because Paul was disturbing the group session, the social worker took him for a walk. In contrast to his behavior in the group, the youngster responded to this individual attention by talking freely about himself, and he revealed his fear of failing the third grade, a fate to which he seemed already resigned.

Shortly after Paul and the social worker left, the group broke into individual sessions, during which all three therapists elicited further data on intrafamily relationships. Data from these three sessions confirmed the observation made in the opening conference, that the mother's hold on her son interfered with the boy's ability to relate constructively to his father. The parents' negation of each other's influence seemed to leave the youngster in the driver's seat.

After about 40 minutes of individual sessions, the team and the family reconvened for the final conference of the intake procedure. The team now directed attention to the boy's difficulty in having any respect for his father. The mother responded by complaining that her husband had withdrawn from communicating with her to such a degree that he gave her no basis for confidence, even in his

occupational stability. His withdrawal seemed to the team an understandable but unfortunate response to her controlling ways. Team members also pointed out that the boys made their attendance at school a responsibility of their mother. This dependency was another way they had of dealing with her control. Her fostering of this dependency prolonged their immaturity.

The father seemed to respond to this discussion as though it empowered him to take over a greater degree of management of his son, but he was wisely reluctant to promise to do more than think about it during the weeks until the scheduled MIT. The mother showed considerable doubt as to whether her husband could provide better leadership, but she seemed attracted to the idea that he might feel stronger now that he knew of her need of him.

As the family prepared to leave, they felt some misgivings but were disposed to study themselves. The team expressed confidence in the family's ability to study themselves and to cope with the situation at home. However, they conveyed their realistic doubts about Peter's readiness to conform to acceptable standards of behavior in the community and suggested that if the boy should get into further trouble in the next few weeks, the authorities should be asked to return him to the hospital rather than to the state training school.

We did not hear again from the Jones family until three weeks later when they returned for two days work with the team.

Staff Briefing Session

The MIT staff met for half an hour before starting the meeting with the family. In this briefing session the staff reviewed all the information on the family that the various referral sources had supplied and that had been gained during the intake session.

In addition to the basic team (i.e., members of the research project), those present at the briefing session for the Jones family were Dr. Y., the house physician who had worked with the boy in the psychopathic hospital, Mr. T., the psychologist who had tested him, and a medical student who took part as an observer during

team conferences and team-family sessions, and who spent some time with Paul in the playroom on the first morning. The conferees decided to invite the hospital chaplain to participate in the work with this family. This was due in part to our interest in studying the role of a medical center chaplain, and in part because Peter had recently joined a religious sect that was more rigid and "fundamentalist" than the church his parents attended. We thought that Peter's move might have caused some religious conflict within the family. Moreover, we considered it appropriate to include the chaplain on the team working with the Jones family because of our observation that family members had difficulty trusting each other and ourselves, and we thought the family could discuss with the chaplain their lack of trust in the professional team.

During the briefing session, a telephone call was made to the hospital chaplain inviting him to join the team during part or all of the two-day work. He had previously expressed considerable interest in this research project, and the possibility of his taking part in the work with one or more families had been discussed at some length. The chaplain agreed to come to the clinic and join the opening team-family conference around 10 A.M. Plans were made for the two boys to be withdrawn from the team-family conference after the chaplain had an opportunity to meet the family and to observe them briefly as a group. Mr. T., the psychology resident, agreed to invite Peter, the manifest patient, to a private interview, and the medical student was assigned the task of observing the younger brother Paul and keeping him occupied in the playroom. After a short team-parents conference, designed to provide the parents with an opportunity to talk with the team without their sons being present, the woman social worker was to invite Mrs. Jones to a private conference. The rest of the team would then spend some time with the father. Overlapping interviews were planned for the last 30 to 40 minutes of the first morning session.

The accompanying flow chart (Tables 2-1 and 2-2) kept by the secretary during the two-day period helps to visualize the sequence of group and individual interviews. The four vertical columns repre-

Table 2-1.
FLOW CHART: JONES FAMILY, FIRST DAY OF MULTIPLE IMPACT THERAPY

9:00	Team briefing conference				
9:30	Team-family conference				
10:00	Chaplain joins conference at 10:00				
11:00	Office A Mr. Jones with Dr. Serrano, Dr. MacGregor, Dr. Y., and Chaplain	Office B Mrs. Jones and Mrs. Ritchie	Office C	Office D Peter and Mr. T.	Playroom Paul and Medical student
11:30	Mr. Jones with Dr. Y. and Chaplain	Dr. MacGregor overlaps		Dr. Serrano overlaps	
12:00	Lunch and team conference				
2:00	Mrs. Jones with Dr. Mac- Gregor and Dr. Serrano	Mr. Jones and Mrs. Ritchie	Peter and Chaplain	Paul and Mr. T. (testing)	Waiting room
2:30	Mrs. Jones and Dr. Serrano	Dr. Y. overlaps	Dr. MacGregor overlaps		
3:30					
4:00	Team-parents conference				
4:30	Team-family conference				
					Peter and Paul

Table 2-2.
FLOW CHART: JONES FAMILY, SECOND DAY OF MULTIPLE IMPACT THERAPY

9:00	Team conference				
9:30					
10:00	Team-family conference				
10:30	Office A Peter with Dr. Serrano and Dr. Y.	Office B Paul with Mrs. Ritchie	Office C Mrs. Jones with Dr. MacGregor	Office D Mr. Jones with Chaplain	Waiting room
11:00				Peter with Dr. Serrano and Dr. Y. overlap	
11:30			Mrs. Ritchie overlaps	Mr. Jones and Peter	Paul
12:00	Lunch and staff meeting with consultants				
2:00					
2:30	Peter with Dr. Serrano and Dr. Y.	Paul with Mrs. Ritchie	Mr. Jones with Dr. MacGregor	Mrs. Jones with Chaplain	
3:00	Paul and Mrs. Ritchie overlap			Dr. Y. overlaps	
3:30	Peter and Paul with Mrs. Ritchie				
4:00	Team-family conference				



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sent offices. The solid horizontal lines represent beginning and ending of sessions. Dotted horizontal lines indicate persons entering or leaving an ongoing session for overlap or for other reasons.

Basic team

Dr. Serrano, psychiatrist
Dr. MacGregor, psychologist
Mrs. Ritchie, social worker

Trainees

Dr. Y., psychiatry resident
Mr. T., psychology resident
Chaplain
Medical student

Family

Peter
Paul, younger sibling
Mr. Jones, father
Mrs. Jones, mother

Opening Team-Family Conference

This conference opened with introduction of new team members, and a few pleasantries. In response to the team's request to be brought up to date on events in the Jones family since the previous session, Mrs. Jones reported that Peter "managed to get kicked out of school and is working." Peter and Paul both spoke about their dislike of school. (PETER: "You just sit"; PAUL: "Schooltime seems slow and playtime flies.") Mr. Jones and Peter spoke of the boy's job at a filling station; father helped him to get it, but it's up to Peter to keep it. Peter spoke enthusiastically of his enjoyment of his work; Mrs. Jones spoke with equal eloquence of the improvement in Peter's disposition. Both mother and son seemed intent on showing that their problems were solved. The chaplain joined the session at 10:00 A.M., and Dr. MacGregor summarized briefly the family situation and recent developments.

The use of the summary to the entering therapist (overlap sum-

mary) is described in Chap. 3. The following excerpt from the tape recording begins shortly after the chaplain's arrival, and illustrates an opening team-family conference.

DR. MACGREGOR: We saw the Jones family about three weeks ago. Peter had been sent to state school by the juvenile court—really around a contempt-of-court-type issue. There he had a hearing scheduled for a violation—use of a family car, primarily—and some pretty dangerous looking fights he was in or about to get in, or got connected with. The judge told him to be on his good behavior until the hearing. This is what was violated. This led to his going to state school. During that initial planning visit they had here, Peter tended to push aside the general discussion by making an issue of “Well, there isn’t anything else that matters except I’m going to have a motorcycle,” or a motor scooter, I forget which. A motor scooter, wasn’t it?

PETER: Yes sir, it was.

DR. MACGREGOR: There was a motor scooter in existence and various things had been done about it, but there was no interest at that point that he was ready to talk about except “When do I get the motor scooter?” And now that they’re back on schedule, the issue has a kind of similar flavor. He tells us that he wasn’t interested in school. He didn’t want to go to school. So he decided not to go to school. The school folks didn’t agree with this, so he got himself kicked out of school. He’s had about three weeks or less in the Lyncrest school this year. And now he is working, and with considerable pride and enjoyment of the work, in a service station, which is managed by a manager who works, as do a number of other managers in this chain of stations, for Mr. Jones, the general manager. Now I’m trying to pick up this theme, because the theme is something of “Dad pays the fiddler and he calls the tune.” And I suspect this has consequence for how the family gets along.

MRS. RICHIE: Let’s report the really positive, constructive thing that Mrs. Jones has contributed. Actually Peter’s disposition has improved a great deal since he has been working; he’s easier to live with and pleasant to get along with. But the issue about planning

ahead for the future is not settled. He has a filling-station job that he likes and he figures that this will be a job that he can keep until retirement age.

DR. SERRANO: The problem is that Peter doesn't seem interested in any particular specialty. He is only interested in filling tanks, changing tires . . . that's about it, though he could go further.

CHAPLAIN: ¹ How old are you?

PETER: Fifteen.

DR. MACGREGOR: [*First speaking to the chaplain*] Well, I want to press a little bit more into the uncomfortable implications of the position that Peter has occupied in the home, in that Dad, having a rather demanding job, is perhaps less in the home than Mother.

[*To Mrs. Jones*] Mother is not the kind of housewife who is strictly at the mercy of her circumstances. She has worked in her time as a trained beauty operator, but she has been more Peter's captive audience [*Turning to Mr. Jones*] and I'm wondering if Peter has more to say about what your wife does than you do. Peter seems determined to run the whole show.

MR. JONES: That's quite possible.

DR. MACGREGOR: But is it uncomfortable?

MR. JONES: Oh, yeah, at times. It gets a little aggravating.

DR. MACGREGOR: [*To Mrs. Jones*] Are you controlled this way?

MRS. JONES: Oh, I don't know. They all control me, it seems like. It seems like I just jump and run when they holler.

MR. JONES: I wouldn't say that at all.

MRS. JONES: [*Laughing*] No, Daddy doesn't get as much as the boys get, I'll have to admit.

DR. MACGREGOR: You mean you're confronted with three "children," each of whom have to get so much . . . ?

MRS. JONES: Yeah.

DR. MACGREGOR: And this. . .

MRS. JONES: And this one, "Take me, get me."

DR. MACGREGOR: Do they get it at each others' expense?

¹ Since this is regarded as in-service training for the chaplain and the resident, their names are withheld.

MRS. JONES: Well, I don't know. It just seems like there's time. I just try to work the time out for each of them as best I can, but [*Pointing to Peter*] this one. . . .

DR. MACGREGOR: I'm wondering if they're—if they're trying to get out of you something that gives you less opportunity to love.

MRS. RITCHIE: I wasn't clear when you were saying, "I divide up the time as best I can, but this one. . . ."

MRS. JONES: Well, this is the domineering one: "Take me, get me, I want to go here, I want to go there."

MRS. RITCHIE: And he says "frog" and you have to hop?

MRS. JONES: Well, most of the time I do. Until he pushes me so far, and then I don't hop.

PETER: You usually hop when I ask. If she's not busy, then she'll do it, but if she's busy. . . .

MRS. JONES: Well, it's just according to the mood I'm in, mostly.

At about this point, according to the agreed plan, Mr. T., the psychology resident, invited Peter to accompany him to another office for an individual session, and Paul accepted the medical student's suggestion that they move to the playroom. The conference with the parents continued for about half an hour. Then, as indicated on the flow chart, Mrs Ritchie and Mrs. Jones moved to a smaller office for an individual interview while Mr. Jones remained with several male team members.

Individual Sessions

The early individual sessions are illustrated by the following tape-recorded excerpt from the session between Mrs. Jones and the social worker.

MRS. JONES: But Paul is turned a lot different from Peter. Paul likes to do things, where Peter never did. I mean he didn't ever want to do anything like that around the house and I just never did make him, because Peter was sick all of his young life. In fact, when he got up this morning he had asthma so bad he was about to choke up. We had to have the doctor out to the house a couple of weeks ago, Sunday night, to give him a shot.

MRS. RITCHIE: Yes.

MRS. JONES: That is the first time he has had asthma now in about three years.

MRS. RITCHIE: Was this in relation to his stopping school and starting on the job?

MRS. JONES: Oh, he had already started work.

MRS. RITCHIE: Yes.

MRS. JONES: Because he . . . well, I think he started the day before. Yeah, I think he started on Saturday and on Sunday night he came in and he said he was sick.

MRS. RITCHIE: Yes.

MRS. JONES: He lay down on the divan and he was breathing so heavy, and I could tell it was something more than asthma—he was making a noise both ways—and I called the doctor and he came out, and sure enough he had a chest infection along with that.

MRS. RITCHIE: Yes.

MRS. JONES: And he said, "Mother, I've just got to get well, because I just can't miss the first day at work. I've just worked two days and I sure can't miss tomorrow." And he did go to work Monday.

MRS. RITCHIE: It wasn't typical of asthma. It was an infection?

MRS. JONES: It was both.

MRS. RITCHIE: He had some asthmatic symptoms with the infection?

MRS. JONES: He had asthma. This morning and last night he had pure-dee asthma like he used to have.

MRS. RITCHIE: Was there any suggestion or consideration of canceling or postponing the trip here because of this asthma attack?

MRS. JONES: Oh no, oh no, he didn't have it until he got here. He was coughing some when he went to bed and then this morning he was terrifically choked up.

MRS. RITCHIE: Yes.

MRS. JONES: But then he was over it. See, now after he gets up and moves around it loosens up everything. Of course, naturally,

lying down it is hard for anybody to breathe if there is any kind of congestion. . . . Maybe I love them too much [*Long pause*].

MRS. RITCHIE: What do you mean, Mrs. Jones?

MRS. JONES: I don't know [*Crying*]. It just breaks my heart to see Peter like he is. That's why we tried to do everything to straighten him out because he is a good kid. I think this is what hurts so bad, because I know he's good and I think he just got mixed up with this bunch of kids and got off on the wrong foot. But since he's been working he isn't around them like he was, and I think that's one thing that's helped him so much. There's all the difference in the world when he's around them and when he isn't. If Peter were bad, I mean, you know, like the kids you've seen that are bad and mean and ornery, well, you could understand it, but he isn't. He does things that he shoudn't do; all kids do. I told Peter one time when we were having so much trouble with him, I said, "Peter, it would just tickle me to death if I could be like a lot of these mothers who just don't care." He was fussing because I asked him to come in at a certain time and he hadn't gotten in then. And I said, "You know, there are mothers that don't even care if their kids get home or not." And I said, "Maybe it would be nice if I could be that way, but I can't." And he said, "No, Mother, I don't want you to be that way." But he has always said, he has said repeatedly, "Mother, I don't ever want to hurt you, but I want to hurt Daddy." And I don't know why because Fred (Mr. Jones) has been wonderful to him, in fact, I think he might have been too good to him. In fact, I think if he had picked him up and blistered his little rump about fourteen times it might have helped this situation a long time ago. Of course, as I say, when he was little, Fred tried to and all, but I wouldn't let him. That's something else I've tried to watch myself with Paul, because that's a mistake, I know.

MRS. RITCHIE: Um.

MRS. JONES: But it's just that I don't know. I just had Peter by myself so long and then when Fred got back from the service,

well, Peter didn't know him from Adam and I just couldn't stand the thought of him spanking Peter. I just couldn't do it. So I'm sure that was my fault there, what happened.

MRS. RITCHIE: I seem to remember saying this when you were here before, and yet I can't help but say it again, "as though Peter were more your child than your husband's child."

MRS. JONES: Well, I guess I feel that way. I think if Fred had been with Peter like he has been with Paul throughout all of his life there would have been a difference in the way that they feel toward each other. I've just changed, I don't know.

MRS. RITCHIE: Well, I think you do know. I don't think you know that you know, but I think you've already told me that you really are aware of some guilt for having overindulged and overprotected. . . .

MRS. JONES: Oh, yes.

MRS. RITCHIE: . . . and spoiled and spoiled.

MRS. JONES: [*Crying again*] I'm sure. [*Long pause*] Oh, I don't know, I think I just got upset with all this. It's just taken me a while to get myself all back together. Just like I said, this is the first time I've had any peace of mind in about three years with Peter. So it's definitely a relief to me to be here.

MRS. RITCHIE: Yes, and where do you find the strength, the inspiration, the courage, and whatever it takes to take this firm stand with him on this business of making his own bed and picking up his own clothes before he goes to work in the morning?

MRS. JONES: I don't know.

[*Meanwhile the men were over in the next office.*]

MR. JONES: I was staff sergeant and I sent that money for her to live on.

DR. MACGREGOR: [*To the chaplain*] Mr. Jones had the experience of getting home from the service. Peter was convinced that the picture on the table was his father more than the strange man who walked in.

MR. JONES: Well, yeah, see, I was sent overseas the month after he was born and I didn't see him until he was 19 months old. Any-

body ask him who his daddy was, he'd point to that picture, you know, that was his daddy. And it was that way until quite a while after I got home. [*Chuckles*] That was still his daddy.

RESIDENT PSYCHIATRIST: In fact, this wasn't such a very funny thing when you came home?

MR. JONES: No! It wasn't.

CHAPLAIN: How did you overcome that with him?

MR. JONES: Well, after he got a little older, he finally realized that I was the guy in the picture.

DR. MACGREGOR: Is it overcome?

MR. JONES: Well, maybe not.

DR. SERRANO: Well, at that time your wife was living with her mother so that she had full time to care for the baby. She didn't have any other chores or outside work; so we have a picture of the mother looking at your picture, crying, and of the child being involved in this scene. Later he may have identified you as the one in the picture that made Mother cry.

RESIDENT PSYCHIATRIST: You and your wife must have had quite a bit of friction when you came back about your feelings conflicting with hers as to how this boy was going to behave when you first moved in.

MR. JONES: Well, that's true. You know, when they were staying there, she had devoted all her time to him and wasn't ready to do anything else. I mean, just living his whole life for him. If I even corrected him for doing anything, while she was standing there, well! She, of course, corrected him for things he didn't need correcting for. That kind of hacked me. It was quite a bone of contention.

RESIDENT PSYCHIATRIST: Then he got asthma, didn't he?

MR. JONES: He had asthma till he was, oh, 6 or 7 years old.

DR. SERRANO: He had some other kind of allergy, too.

DR. MACGREGOR: Did you feel any resentment that he was getting the kind of nagging that a husband is entitled to?

The individual sessions with the two boys were not tape-recorded. The medical student simply kept Paul occupied in the

playroom and had an opportunity to observe an immature 9-year-old. The psychology resident, Mr. T., was concerned and discouraged by Peter's "tough" exterior and attitudes. He later reported to the team that Peter was a living example of the popular conception of a "no-good hood."

Overlapping Interviews

According to the previously laid plan, after about 30 minutes of the multiple-therapist session with Mr. Jones, Dr. Serrano joined Mr. T. and Peter. (The psychiatrist's dictated summary of the overlapping session with Peter appears on p. 33.) Dr. MacGregor joined Mrs. Ritchie and Mrs. Jones, leaving Mr. Jones with the chaplain and Dr. Y. to continue together until the luncheon break.

The following excerpt illustrates an overlapping interview.

MRS. RITCHIE: It almost sounds as though you are saying, "Well, I really feel, Mrs. Ritchie, you ought to know I'm a pretty inconsistent person that says one thing or another thing depending on whim, and that the other members of my family never really know..."

MRS. JONES: Well, that's true, that's true. It's the mood I'm in, the way I act, and that isn't good, I know, I realize it. [Pause] I can see my faults very easily. I have plenty of them, but I do try to do my best; if I do anything I try to do my best. If I don't do it, period.

[Phone rings, Mrs. Ritchie answers it.]

MRS. RITCHIE: Yes, come in now. [Hangs up.]

MRS. JONES: I'm moody. If I'm in the mood to work, I work. If I'm not, I don't.

[Dr. MacGregor knocks on the door and enters.]

MRS. RITCHIE: [Looking more at Mrs. Jones than at the doctor] We've gone off on a tangent and I'm afraid Mrs. Jones may feel that I've pushed her into the position of having to use this as more of a confessional than a therapeutic session. I mean [Turning to Mrs. Jones] you've been recalling some faults.

But two things that have really impressed me are how very

strongly Mrs. Jones feels that it's inadvisable for her son to have a motor vehicle before he gets his driver's license. This is true, whether the vehicle is given to him or whether he buys it himself. And, as we discussed this, I almost got the feeling (and Mrs. Jones will have to correct me if I'm wrong), that during his younger years after his father came back from the service, she really quite consciously stood between the boy and his father, feeling that after all the boy had been with her and she understood him and the father didn't, and he was a sick child and needed his mother. Now the father is going along with Peter on the motor scooter deal, and is prepared to sign the papers for Peter to buy it. The father is trying to buy his son's affection, in spite of the mother. Last year when Peter got his first motor scooter, Mrs. Jones was not consulted and did not even know of the plan until after the scooter had been purchased and driven home by Peter. But before they went out yesterday she made an objection to another scooter and got no response from her husband.

Mrs. Jones, in dancing attendance on her "three boys," Fred, Paul, and Peter, is behaving in a way consistent with her own background, but it is not appropriate or helpful to the three men. It amounts to doing and doing and waiting on them and spoiling them when she's in the mood, but every once in a while she doesn't want to be pushed around any more, and then she takes a stand about something. The good relationship, as she describes it, is much better between her and Peter than between her husband and Peter. It also involves a good deal of horseplay such as wrestling together and tickling each other and having that kind of fun together. This, I think, is playing with fire with a physically mature 15-year-old boy because of the danger, as we've seen in some instances, of it being very emotionally and sexually stimulating to adolescents. I don't know how much any of this ties in with what has been going on in the other office, but this is what we have been talking about.

DR. MACGREGOR: [*Addressing Mrs. Jones*] This is very much what we've been talking about. I feel this two-day period is going to be

rough for your husband. I tried to advise him of this before we got very far along. I called attention to the fact that there was a group of us who seemed to be critical of him, and I encouraged one of the others to speak on his behalf because I felt critical. And this is the way it occurred. I said to your husband, "There were tears in your wife's eyes last time when we talked about her unfulfilled feelings, while you showed no emotion. Today it is as though we are having a bull session here like a group of boys while your wife is working with Mrs. Ritchie."

The chaplain then spoke in defense of Mr. Jones and pointed out that this man has done a rather splendid job of being a provider for his family, in view of the odds that were against him in his earlier life. I saw the comparison between his role in life and yours. You have had to specialize in motherhood and he in the role of provider. All your associates admire you, undoubtedly, as a woman and as a dutiful mother. As a good provider, he is *not* experiencing all the joys of manhood, and specializing on motherhood you're not experiencing all the joys of *womanhood*. To this the father said, "Yes, I would like to get closer to my boys."

MRS. JONES: Sure he is. Yes.

DR. MACGREGOR: I feel somehow that he's missed part of what belongs to his manhood, but the solution is certainly not to become more of a mother to his boys.

MRS. RITCHIE: Or a brother.

DR. MACGREGOR: Exactly. Dr. Serrano put it this way, "You are trying to relate to your boys more, but as their equal." [Pause] At this point things were kind of tense in the room and I suggested that it might be easier to follow some of these points if he talked with one or two of us, so Dr. Serrano went to participate in the interview with the son, and I thought I'd come in here and tell what we were discussing. There's a criticism of what he is not doing, but also a strong feeling on our part of what he is missing.

MRS. RITCHIE: Let me speak up for Mrs. Jones and what she is missing! At this point she feels terribly deprived of the support of her husband on a few issues that seem very important to her.

The boy's owning and operating a motor vehicle without a license involves concern for the boy's very life, and concern for the fact that he was picked up once for it and this is, in most communities, a violated parole.

MRS. JONES: It certainly is. That's all it would take.

DR. MACGREGOR: This is really something to work with, because what you're asking for, what you really want of your husband, is a far greater compliment to him than what he feels you're asking for. He keeps giving the message, "Think of me as a provider."

MRS. JONES: Yeah, I know it. He always says, "Well, I have always provided for you." I say, "Nobody knows that better than I do."

MRS. RITCHIE: And it's not that you're unappreciative of this, but you believe a man has more to give than just providing.

MRS. JONES: Yeah! Sure!

DR. MACGREGOR: [*Slowly*] I think he needs to find this out. I think as we say it to him it's felt as an insult. I don't know how we could show him that we see it as something more admirable than he thinks it is.

Dr. Serrano, who joined Mr. T. and Peter at 10:30, later dictated his impressions from this session as follows:

"The rigid code of the reform-school students seemed to suit his needs just as does his recent affiliation with a fundamentalist church. He put 'Mother' on a pedestal, fighting anyone who used the word in a derogatory sense, but the image did not fit his description of his own mother. The fighting seemed to prove his masculinity, the proof being necessary because of his self-depreciation starting in early childhood. He had asthma and developed slowly until puberty, when he caught up with his age group. He seemed delighted to play the role of the dangerous hoodlum at this time. His search for a strong masculine figure that he couldn't find in his father produced the bravado. His poor judgment, the inappropriateness of his behavior, and the antisocial acting out seemed to confirm the hospital psychiatrist's impression of a preschizophrenic process."

Meanwhile, the psychiatric resident and the chaplain continued with Mr. Jones in a session in which the resident discussed further Mr. Jones's insistence that everything was all right because he was a good businessman. He didn't talk much. He typically sat nodding and smiling. The doctor attempted, with no success, to get Mr. Jones to see that involvement with his work was not sufficiently satisfying. Mr. Jones did state that as soon as possible he was going to put Paul in military school to "get him out of Mother's clutches."

The team then went to lunch, and as was then the practice, the family were encouraged to try to discuss among themselves during the lunch hour what had gone on during the morning.

Team's Luncheon Conference

Usually, one of the project's directors, acting as a consultant, joins the team for the luncheon conference. At this conference, the team members exchange impressions and information, critically appraise the way in which they have related with and reacted to individual family members, and discuss the next steps. Trainees and inexperienced therapists are sometimes prone to overidentify with individual members or to develop exceedingly critical or negative attitudes toward them.

When Mr. T., the psychology resident, reported on his interview with Peter, he revealed his negative, even hostile, impression of the boy. Other team members considered Mr. T.'s attitude to be an overreaction to the youth's façade and bragging. Some team members felt that Dr. Serrano's impression of Peter (p. 33) was unduly influenced by Peter's reaction of arrogant bravado to Mr. T. The chaplain wished to talk with Peter after lunch. The group approved, feeling that the chaplain would win Peter's trust better than a psychiatrist, a psychologist, or a social worker.

Dr. Y., the psychiatry resident, obviously overidentifying with Peter, expressed a very hostile attitude toward the father.

According to the usual procedure for the first day of MIT, the therapists who saw the parents of the family exchanged patients for

the afternoon session. Mrs. Ritchie, who had seen Mrs. Jones privately in the morning, was to interview Mr. Jones in the afternoon, and Mrs. Jones was to see Dr. Serrano, who had talked with her husband during the morning. At the luncheon conference Dr. Serrano expressed strong conviction and strong feeling that the mother must be stopped from crippling her son. Dr. MacGregor thought that Dr. Serrano was overreacting to Mrs. Jones, and that he might be punitive toward her. Dr. MacGregor, therefore, asked to be present at the start of her afternoon session with Dr. Serrano.

Afternoon Sessions

Mrs. Jones and Dr. Serrano. Dr. Serrano began to interview Mrs. Jones, with Dr. MacGregor present. Dr. MacGregor, noting that the constructive intimacy of the situation should be respected, left after 15 minutes. He explained in leaving that he had gathered what he needed for overlapping in the interview between the chaplain and Peter. In this session Mrs. Jones expressed surprise that her son had violently attacked anyone at the reform school who spoke disrespectfully of mothers. She described her early tender relations with Peter and how her husband, since his return from the service, envied her son. When he tried to discipline the boy, she prevented it because she perceived jealousy beneath his anger. Mrs. Jones blamed herself intellectually for her overprotectiveness, but showed little real wish to change her attitude toward her elder son. She recognized that the more she favored him, the more rejecting and hostile he was at home. She felt it was too late to change things. She obviously preferred to keep things the way they were and to maintain control over all three men in her family through divisive techniques.

In reviewing her own life experiences that might have contributed to this attitude, Dr. Serrano perceived that Mrs. Jones's controlling ways grew out of fear of becoming aware and losing control of her own hostile feelings. While denying any resentment for her mother's frequent and severe spankings, she recognized her own inability to spank her children and her strong objections, through-

out Peter's childhood, to her son's being physically corrected by his father.

*Peter and the Chaplain.*² The initial belligerence in this interview was manifested by Peter's ostentatious paring of his nails with a switchblade knife. When this behavior was interpreted by the chaplain as an unnecessary maneuver to enhance and demonstrate Peter's masculinity, spontaneously, and with evident relief, Peter handed the knife to the chaplain and quickly settled into a discussion of the reasons for much of his unacceptable behavior. He indicated his awareness that most of his fighting was to defend his manhood in the face of attack or insult from other boys rather than to defend his mother or girls of his acquaintance as he had previously asserted. He expressed clearly that the object of most of his ill feeling was his mother who, he felt, was subtly robbing him of his freedom. His estimate of his father was, "If I were he, I'd have left her a long time ago."

Dr. MacGregor joined Peter and the chaplain in an overlapping session. In his summary to Dr. MacGregor, the chaplain developed the theme that Peter had felt he had to fight as a way of proving manliness. Dr. MacGregor related this to a family pattern, in that the father attempted to prove manliness only by being a good provider, and the mother's sole effort to prove womanliness was by being a good mother.

Mr. Jones and the Social Worker. In his interview with the social worker, Mr. Jones was naively inconsistent. He maintained, on the one hand, that the marriage was a successful one, that he and his wife were happy together and had no dissatisfactions or disagreements with each other. On the other hand, he complained that he had been "pushed" into the marriage by Mrs. Jones. She had insisted they marry before he went overseas, rather than wait until after the war as he would have preferred. He was equally inconsistent in his attitude toward Peter. He described how he and his wife had agreed a week ago that Peter should not have a motor scooter or a car until Peter secured a driver's license, and how, on

² The tape recording of this interview was technically unsatisfactory.

the following day, he had gone with Peter to shop for a motor scooter. Mr. Jones had refused to buy it only because it was too expensive.

Dr. Y. later joined this session. The following excerpt shows the tenor of the conference.

MRS. RITCHIE: When it came to being the father in terms of decisions, restrictions, and discipline, you didn't do it.

MR. JONES: Well, I did for a good long while and I finally decided it was doing more harm than it was good, so. . . .

MRS. RITCHIE: Doing more harm than good?

MR. JONES: Well, every time I'd correct him, she'd get on the boy's side, you know, and then go to chastising me. . . . When I was correcting him for something, she was taking his side. And the only reason she was doing it was because I corrected him; she knew that the boy was wrong. And it happened time and time again, well. . . .

MRS. RITCHIE: She was chastising you?

MR. JONES: Well, I mean she was—uh—taking up his side, whatever it was. She was always on his side and would go to fussing at me for correcting him. I shouldn't do that and this, that and the other.

RESIDENT PSYCHIATRIST: What did you do about that? What did you say to her then?

MR. JONES: Well, I'd take her into the other room and I'd tell her. . . . I corrected him because I thought he needed correcting. I explained it to her and she went along with it and said, "Well, I don't know why I do that," but she did do it every time. Finally, I just. . . the heck with it.

MRS. RITCHIE: I feel, and my guess is that your wife has to live with, the absence of any indication of really tender regard for her as a woman and for her feminine needs. You present you and her as getting into hassles and you back down every time.

MR. JONES: Well, I don't mean to leave the impression that we argue, hassle. . . .

MRS. RITCHIE: You haven't given that impression. You've given

me the impression that you lost battle after battle and then you gave up.

MR. JONES: Well, I think a lot of my wife and I believe this, that it was such a big issue with her that if I were to keep on correcting him, like I thought he should be corrected, I just don't know if our marriage would have lasted, because she . . . this was such a big thing with her.

After an hour's discussion, Mrs. Ritchie telephoned Dr. Serrano, who was seeing Mrs. Jones, to suggest a joint conference of the three team members and both parents. She did this to clarify some discrepancies in the stories of the parents. In addition, the corrective influence of an additional therapist, preferably a male psychiatrist, was needed to help counteract the increasingly hostile and critical attitude of the psychiatric resident against Mr. Jones. The resident was openly critical of Mr. Jones's passivity and defensiveness, with little evidence of sensitivity for the man's growing feelings of inadequacy and failure. From experience in this teaching clinic, the social worker felt that the young male resident would accept leadership and guidance from a male psychiatrist more easily than from a female social worker.

Because the session with Peter was also terminating at that time, Dr. MacGregor and the chaplain joined the parents-team conference. Peter was sent to the waiting room where his brother would join him and both could have a soft drink or otherwise amuse themselves until they were invited to join the group session with their parents [1].

Reconvened Parents-Team Conference. The team's efforts to bring together the various themes of the day's work are indicated in the following excerpt from the parents-team session:

DR. MACGREGOR: I'm quite excited right now.

MRS. JONES: You are? Well that's good.

DR. MACGREGOR: You'll hear this again from the chaplain. This boy has said some things that show he's got real understanding. This did not seem possible from our earlier view.

MRS. JONES: Well, good. I was sitting here holding my breath wondering in which direction you were going to go.

DR. MACGREGOR: For a while I listened to the conversation between him and the chaplain and I thought, "The boy talks nicely to the chaplain." So I'd come in. I'd say, "Boy, you're discouraged and you're trying to sell this man on how discouraged you are." And, "You've got a pattern here that I've been afraid will take over, that if you ever stop fighting you're going to get depressed. Well, look what you said in here a few weeks ago, that you would allow something destructive to happen to you because it would make your parents sorry." Immediately, he saw what I meant. He read the pattern back to me and I knew at least that he wasn't talking nicely to the chaplain just because he was a chaplain; he was letting me in on his thinking too. He asked us the question, "What's my part in helping Mother find her satisfactions with Dad instead of with me?" And then he went back over the history. I don't know whether one of you had reviewed this history with him of how, from the time Dad first came home from service, the boy would get all the attention. Then he'd get mad while he was talking and say, "I wish to hell Dad would get some of this nagging that I get."

RESIDENT PSYCHIATRIST: Mrs. Jones, this is one thing we wanted to talk to you about. Mr. Jones has just told us that as far as he can tell, as far as he's concerned, to use his words, everything is hunky-dory between him and his wife. The only real problems in this marriage are with the children.

DR. MACGREGOR: But this boy is mad about carrying an emotional load in relation to his mother that is too much for him. He'd like to be able to feel that Father is first with Mother. This would get Mother off his back.

MRS. JONES: Gosh. I didn't know I was such a demon. How have you lived with me all these years?

DR. MACGREGOR: We were talking about an example of a building held up by pillars that stand neither so close together that they lean on each other, nor so far apart that the building falls between

them; and Peter pictured himself and you, and I drew in other members of the family, making a faulty structure. And he said, "But if Mother stops leaning on me, she stops leaning on me to lean on what?" Now, this seems to be an unbelievably smart question, because he still sees Mother as needing to lean, and he's beginning to get a little feeling of being a separate person himself. He can stand a little bit on his own. He still can't picture Mother as having this same kind of growth and self-confidence. And we said that we suspect that Mother's self-confidence can grow.

DR. SERRANO: I've been talking with Mrs. Jones. During all these past years, especially until three years ago, she didn't feel comfortable when Mr. Jones would try to make the boy mind. And there was a time when Peter was 12 and objected to being told, "Well, you don't go." He took a switchblade and pushed it in front of his father, saying, "Well, you are not going to be enough of a man to not let me go," or something of this nature. Wasn't it this way?

MR. JONES: Pardon?

DR. SERRANO: Wasn't this the way, when Peter was 12, he pulled out a switchblade and threatened you to stop him?

MR. JONES: Yeah. Uh-huh.

DR. SERRANO: This was so shocking to you that you didn't know what to do, and you asked your wife what to do in such. . . .

MRS. JONES: Well, I said he could go.

MR. JONES: Well, my wife and the little one were back in the other room. I asked her if she wanted him to go; she said, well, she didn't care, just tell him to get on out.

DR. SERRANO: Then Peter left the house. Another thing he did was to hide somewhere when the family pastor came to see him. The story the child finally told the pastor was that he was very mad at Father for coming home drunk and beating his wife and what not; something that never happened. He made up such a story to account in some way for the unspoken unhappiness between his parents.

Mr. Jones is the kind of person who can take quite a lot before getting mad. There was, however, an issue with the motor scooter in which the boy was pulling against his mother and insisted that he was going to take it. Father got so mad that he jumped on him, grabbed him by the neck and threw him in the yard . . . and the mother came and said, "Don't hurt him." And so he said, "Well, if you were not there I don't know what I'd have done to him."

MR. JONES: I let him out of it.

DR. SERRANO: Let him up, actually. What the kid has been doing was to insult Father in the open, and call him all kinds of names. . . .

DR. MACGREGOR: And really wishing that Father would. . . .

DR. SERRANO: Would beat him up.

DR. MACGREGOR: Would show him the limits beyond which he could not go.

DR. SERRANO: Yes. What he is asking for is a good beating.

MR. JONES: Well, I. . . . He almost got one.

MRS. RITCHIE: But at the last minute you backed down.

DR. MACGREGOR: [*Very slowly*] I can't recommend this. I don't think that this boy needs a beating.

CHAPLAIN: He needs something entirely different from that.

MRS. RITCHIE: Not now, maybe earlier.

MRS. JONES: Yeah! But years ago when he tried this, if I'd kept my mouth shut, we probably wouldn't have the problem we have now. Of course, I decided that he . . . it was time for Dad to take over. Well, it was a little late then, because Peter was just a little bit too big. If he had been doing it all along it would have been different.

CHAPLAIN: He made two statements: "If I were my dad I would have left my mother a long time ago," and "The thing she's most consistent at is lying." What he means is that you can say one thing and do another quite easily. Now I think that ought to be brought into the picture. At the same time he feels somewhat

dependent on you and wishes his dad would take over. I think that has a lot to do with this, what you call depression. Is he indeed able to get a license?

MR. JONES: Yeah, I can get him one, but I have to sign an affidavit that it's necessary for him to have to get to and from work. Of course, it would be awful nice. Now one of us has to take him. . . .

DR. MACGREGOR: Well, don't perjure yourself to do it.

MR. JONES: Pardon?

DR. MACGREGOR: Don't perjure yourself.

MR. JONES: No, it isn't exactly an absolute necessity, but. . . .

MRS. JONES: When he's 16 he could get his license.

MR. JONES: When he's 16 he could get it anyway, but it's quite an inconvenience now. I go to work earlier and I either have to wait on him to take him at 8 or close to. . . . I take him about 7:30 when he goes with me.

DR. MACGREGOR: Well, I think the important thing that the chaplain has brought out with him is that he uses getting a car as something to get nagged by mother. If this argument about the car exists between him and his mother, this is just dragging on what they're both tired of. The problem of whether he gets a car has to be a problem between you parents. If the two of you agree that he does or doesn't get a car, that settles the matter.

MRS. JONES: I told him, I told both of them before they got that scooter that I'd much rather he'd have a car any day than a scooter. And I told Peter that at least a hundred times. He knows that I'd rather he'd have a car than a scooter.

DR. MACGREGOR: There is trickery here in that when he went for a scooter you said "go for a car," knowing that he wasn't eligible for a car, because he's not old enough for a driver's license.

CHAPLAIN: Can he get a license for his scooter?

MR. JONES: He can get a license for a scooter.

CHAPLAIN: Why did he not?

MR. JONES: Just too lackadaisical . . . just putting it off.

Peter and Paul were invited in for the last few minutes of the session. The team recommended that the family engage two rooms rather than one at the motel, and Peter offered to cancel his date with a hospital acquaintance and to play with Paul instead so that the parents could get together for a discussion. A definite time was set for the appointment the next morning, and the family left the clinic.

Second Day of MIT: Morning

Briefing Conference. In the team's briefing conference, Mr. T. gave a preliminary report on Paul's psychological tests. Tentative plans were completed for a short family-team conference and for team members' assignments for the rest of the morning.

Family-Team Conference. In the family-team conference, Mr. and Mrs. Jones reported that, contrary to their usual pattern, they had permitted the two boys to get hamburgers and entertain themselves while the parents went out together for dinner. They had, however, ignored the suggestion that they get an extra motel room so that the parents would have privacy. The team accepted the recognition of the spirit of the recommendation, in that the parents dined apart from the boys.

Dr. MacGregor presented to the family a brief and general report on Paul's tests, emphasizing that Paul, like his older brother, was of high average intelligence, and that intellectual limitations were not the basis for his school difficulties. During this entire session, Paul occupied himself with a comic book, and did not betray any awareness or interest in the discussion about him.

The family-team conference then broke up into the following individual sessions: Paul and social worker, Mrs. Ritchie; Mrs. Jones and team psychologist, Dr. MacGregor; Peter and team psychiatrist, Dr. Serrano, and psychiatric resident; Mr. Jones and chaplain. For the overlapping interviews that followed later in the morning see flow chart, Table 2-2.

Individual Session: Paul and Mrs. Ritchie. In the individual

interview with Paul, Mrs. Ritchie attempted to inform him of the test results, and by a clear demonstration of respect for him as a potentially self-reliant, adequate person to stimulate his presumed propensity for growing up. Paul's resistance to her efforts is clear as is his tendency to make himself appear stupid. Following is an excerpt from this interview:

MRS. RITCHIE: In other words the doctor is saying that Paul doesn't need a tutor, that Paul doesn't need all this help from his mother, that Paul is a big boy now, and that he can go to school, and that this is his job and he can do this job himself. Now, do you understand what I'm saying?

PAUL: Yes.

MRS. RITCHIE: What do you think about it?

PAUL: Oh-h-h, I think it's all right.

MRS. RITCHIE: Does it make you feel better or does it make you feel worse, that I'm saying not only that you do not need a tutor, but that you shouldn't have a tutor and you shouldn't have your mother in there helping you so much?

PAUL: Oh-h-h, it makes me feel a little bit better.

MRS. RITCHIE: Yes. [*Long pause*] I wonder if it does. Now you are a big boy, you're 9 years old, aren't you? When will you be 10, Paul?

PAUL: Oh, I thought it was my birthday. I told the doctor, yesterday, my birthday was on October twenty-sixth, but I found out today that it wasn't. But I'm not sure, my mother told me that my birthday was on October twenty-sixth.

MRS. RITCHIE: Well, last month was October. When the twenty-sixth came around, was it your ninth birthday or your tenth birthday?

PAUL: Well, it really wasn't in October, it was in October or in May or July or somewhere in there.

MRS. RITCHIE: Uh-huh.

PAUL: But I know it is the twenty-sixth.

MRS. RITCHIE: I see. Have you ever had a birthday party?

PAUL: Yeah, I've had lots of them.

MRS. RITCHIE: Now, who invited the kids to the party?

PAUL: Oh, I did.

MRS. RITCHIE: What kind of arrangement did you have with your mother about how many people were coming?

PAUL: Oh, she didn't care because she knew there were just, not very few—many of them in the block that I know very well.

MRS. RITCHIE: Of course, the thing that mothers have to worry about is, how many? How much ice cream shall I get?

PAUL: She just bakes one cake, and maybe sometimes cookies, and ice cream and different things.

MRS. RITCHIE: How did you know when to invite them?

PAUL: [*Mumbles something*] I keep on asking my mother when my birthday is and she just—finally she tells me.

MRS. RITCHIE: Do you know how to read a calendar?

PAUL: I don't care about calendars.

MRS. RITCHIE: What do you mean, you don't care about calendars?

PAUL: Well, I can read them, but I don't like to read them.

MRS. RITCHIE: It's a lot easier to ask your mother.

PAUL: Yeah, 'cause most of the time I'm ready to go outside and come back inside to ask if it's pretty close to my birthday.

Individual Session: Mrs. Jones and Dr. MacGregor. Dr. MacGregor's interview with Mrs. Jones was planned to help her with the problems of how she could allow herself more adult satisfactions in living, and how she could let go some of her need to keep the rest of the family dependent on her like children. She expressed grave doubt that the team understood the family. Dr. MacGregor reviewed the difficulties that the family members had in being really close to each other, in really getting to know each other. He also reviewed the parents' difficulties with sexual intimacy. Mrs. Jones agreed that the family members didn't know each other well, but she insisted that she and her husband had satisfactory sexual relations.

The social worker joined Dr. MacGregor and Mrs. Jones at this point, having finished her interview with Paul. She reported that

she had been talking with Paul about his childish dependency. She expressed concern that Paul, the well sibling, was falling heir to his brother's problems and was in danger of being the target for his mother's need to dominate.

Individual Session: Peter and Dr. Serrano. Dr. Serrano had been working with Peter in order to evaluate the depth and durability of his cooperative attitude of the previous afternoon. Following is an excerpt from that session:

DR. SERRANO: One gets the feeling that Mother made of her husband another boy or that he made of himself a boy.

PETER: I think Mother made of him another boy and he went along with it because either it was like that or he was going to be left out all the way. That's the way I see it.

DR. SERRANO: Yes.

PETER: As far as Father's been concerned, I think he's been a good father to both me and my little brother. Mother just hasn't been giving him a chance to be a good husband to her, let's put it that way.

RESIDENT PSYCHIATRIST: You think he's been a good father when he's let your mother do things for you and for Paul you ought to have been doing for yourselves. You think this is being a good father? When he's obviously smart enough to see that this is not right, as he says he's seen it all along. He knows this wasn't really the thing best for his boys, when he just goes right on and doesn't put his foot down hard enough to do anything about it.

DR. SERRANO: Yes, the point is, of course, that he feels Father was good but Mother doesn't let him be good. But this has an impression of bitterness, because one expects Father to take a stand. It is not very comfortable to think, "Well, Father is a weak guy." [2]

PETER: Well, it has been pretty different since I've been back, now Daddy has taken a lot of responsibilities and put his foot down.

RESIDENT PSYCHIATRIST: With Mother?

PETER: Yeah.

RESIDENT PSYCHIATRIST: As far as you are concerned, or as far as Paul's concerned, or what?

PETER: He's just been different, I mean, he's been telling her what he's going to do and it hadn't been like that before—since I got back from Galveston. It's been kind of a change overnight.

RESIDENT PSYCHIATRIST: Is she still being resistant?

PETER: Yeah, she's still being resistant, but it's not doing her much good.

RESIDENT PSYCHIATRIST: You told me last night, or the night before last, when you were looking for a place to stay, they came up to this motel and your mother said, "Peter, do you think this is all right?" And you didn't like that very well, did you?

PETER: No! I didn't like it at all. I thought it was up to Daddy where we stayed or what kind of motel.

RESIDENT PSYCHIATRIST: Naturally.

PETER: I think it was up to him, and so did he.

RESIDENT PSYCHIATRIST: But you went along with her.

PETER: No, no, I told her, I said, "Looks all right to me, but ask Daddy, it's up to him whether we stay here."

DR. SERRANO: Well, I think that this is something to expect because if she feels that your father is putting his foot down and she is losing some ground, she is bound to ask for somebody to be on her side, so it will be two against one instead of being one against the other.

PETER: Can I open a window in here? I'm getting hot. I'm getting sick and everything.

DR. SERRANO: By the way, you said last night you had some problem with asthma. Is it that you've been free of asthma until last night, or is it on and off?

PETER: Yeah, I've had it all my life.

DR. SERRANO: Has it been any better recently?

PETER: I hadn't had it in the last couple of years until about two weeks ago when I got it really bad, and the doctor came out there

and gave me a shot, and then last night I got it real bad and this morning I couldn't hardly stand up. I feel like I could vomit right now. I don't feel good at all.

DR. SERRANO: What happened to upset you? Sometimes feelings and asthma are connected. Yesterday and today we talked about many things which might have upset you and brought back the asthma. [Pause]

RESIDENT PSYCHIATRIST: Do you buy that?

PETER: Yes, sir. I—I guess that's right, because come to think of it, I get asthma when I get worried or something. [Pause]

RESIDENT PSYCHIATRIST: Were you upset last night?

PETER: Yeah, I was upset last night.

RESIDENT PSYCHIATRIST: Yes?

PETER: About thinking about leaving and never coming back.

RESIDENT PSYCHIATRIST: Leaving home?

PETER: No, leaving here.

RESIDENT PSYCHIATRIST: You mean, never coming back to see your girl?

DR. SERRANO: Was that because you have some strong feeling for this girl here in Galveston?

PETER: No. Well, you know what that chaplain told me yesterday, that I should try to really love somebody. Well, I guess that's what's been wrong. I haven't been around anybody that I really loved or anything, so that's what I've been trying to do. Every time I get to where I like a girl a lot, well, Mother steps in and breaks it up in her own little way.

DR. SERRANO: [Quietly] I think that your mother has a real ability to do that.

PETER: She does. And it's Mother's real fault that I got sent to state school. If she'd never made a phone call, that girl and me would never have run off. [Long pause] I guess Mother's just scared she's going to lose me.

RESIDENT PSYCHIATRIST: Why should she be scared of that?

PETER: I don't know, but that's the only conclusion I can come to. Isn't that the way you see it? I mean, like. . .

DR. SERRANO: Yes, well, sometimes the mother thinks that if her son loves a girl she loses everything. She doesn't realize that it is a different type of love. But the mother may have a feeling that "You're betraying me. If you love another girl, you're betraying me. This you do to me."

RESIDENT PSYCHIATRIST: You were saying a while ago that you don't think she shows very much difference between the way she feels about a child and about a husband?

PETER: That's that again. If you bring that up, I think that if I—if Daddy did do everything, and me and him did things together, well, I think she's scared that I'd start loving him and then kind of set her out of the picture again.

DR. SERRANO: One of the angles—I don't know if you see it—is that she is not doing this purposely. . . . [2]

PETER: I know, that's just the way she is.

RESIDENT PSYCHIATRIST: I got the impression that really Mr. Jones is not too happy about this.

DR. SERRANO: You know something? I would like to see Mr. Jones.

RESIDENT PSYCHIATRIST: I was wondering, Peter, if you recognize that your daddy doesn't like this.

PETER: Yes sir, I know he doesn't. I can't blame him.

RESIDENT PSYCHIATRIST: What would you do if you were in his shoes right now?

PETER: I think if I was in his shoes right now, when he got home. . . .

RESIDENT PSYCHIATRIST: As far as your mother was concerned, leaving you and Paul out of it right now.

PETER: Well, I'd get this straightened out. I'd make her start listening to me and I wouldn't keep on slaving for her like I was a little kid, and her screaming at me, because that's the thing that she does to him. If I was him, I'd make her straighten out, and I'd just tell her that I was—that it was going to be different when we get home. Well, we're just going to start all over, and it isn't going to be the same way. She's not going to like it, but he's got to tell her sometime; this can't go on.

RESIDENT PSYCHIATRIST: Do you think your daddy knows you feel that way?

PETER: I don't know if he does or not.

RESIDENT PSYCHIATRIST: Let's go tell him.

DR. SERRANO: Yes.

Individual Session: Mr. Jones and Chaplain. Meanwhile, with the chaplain Mr. Jones discussed his regrets about having sought so much of his satisfaction in his job and so little in his home; he concluded that his elder son, Peter, might be doing the same thing. It is interesting that as Mr. Jones began to feel that he and his son could improve the situation through their own companionship, the two psychiatrists who had been talking with Peter called for a joint session. This joint session went so well that after a few minutes the therapists left the father and son to continue alone until lunch time.

Second Day of MIT: Afternoon

Noon Staff Conference. The midday break on the second day is longer than on the previous day, and includes an hour for lunch followed by a staff conference with the project's consultants. Some review is made of the progress of the work so far, the involvement of team members is again critically examined for overidentification with or excessive hostility toward various family members.³ Plans for specific recommendations to the family (for such things as individual therapy or special education, for example) are agreed upon.

In the Jones case, several members of the team seemed to side with the son and the father against the mother. This was critically examined. The team discussed the possibility that the mother might become depressed should she feel that her husband and son were uniting against her. A decision was reached to use the

³ Overidentification or excessive hostility is a valuable diagnostic tool. It may tell us much about what the family members are up to or about problem areas or blind spots in a team member.

mother's trustful attitude toward the chaplain to help her move from her defensive pattern.

Individual Session: Both Brothers with Social Worker. Plans were made during the noon conference for Mrs. Ritchie to meet in the afternoon session, first with Paul and then with the two brothers together, to help strengthen their relationship. Paul seemed to be fascinated by his older brother, an attitude compounded of admiration and disapproval; Peter was tolerant and rather protective, albeit slightly scornful, of the younger lad. The social worker suggested that Paul might ask his brother for help with homework rather than depend so much on his mother. She proposed that Peter could teach the younger boy a great deal about football, baseball, and other sports. These suggestions were designed to indicate respect for Peter as a suitable companion and model for his brother, and to help Paul more toward a more appropriate age and sex identification.

Individual Session: Mother with Chaplain. The chaplain reviewed with the mother the competitive pattern with men and its correlative, her resistant attitude toward the male therapists. When she recognized that she was showing these same hostile attitudes toward the chaplain as they were talking together, the two of them had a hearty laugh at their predicament. She then told the chaplain that the real reason why hers was a happy marriage was, "I need a man who won't be a man because I have real feelings of being one myself, and he's a threat to me when he comes home and acts like a man."

At about this time Dr. Y., the psychiatric resident, came into the room for an overlapping interview. He was angry toward Mrs. Jones and intended to let her know that she should let her husband be the boss of the family. She made short work of the resident, and then had another laugh, as she and the chaplain recognized that she had revealed her hostile attitude toward men for the second time in ten minutes. Anxious laughter became enjoyable as the chaplain was able to say to her in the presence of the resident,

"Look, you're a delightful person. I'm having a grand time with you. It can be this way if you give your husband a chance." On this note they joined the final family-team conference.

Individual Session: Mr. Jones with Dr. MacGregor. In another office Dr. MacGregor attempted to help Mr. Jones to understand better and appreciate more his importance to his family. The dispelling of doubts about his capacity to function effectively and simultaneously as husband and father would enhance his self-esteem. New doubts about his adequacy had come to him in the past day as he noticed that his wife was becoming more remote while he and his son were becoming closer. The therapist suggested that Mr. Jones was sensitive to matters which influence morale and motivation, that he knew how to lead. Mr. Jones had demonstrated these qualities in his activities as a salesman and in managing an office. The therapist assured him that the concern for his wife that Mr. Jones was now experiencing would guarantee more adult satisfactions for himself and his wife. Then, after discussing fees in a businesslike manner, they entered the final conference.

Final Family-Team Conference.

MRS. RITCHIE: [After describing her discussion with the younger brother] Well, I think that's my biggest contribution to the back-home problem.

MR. JONES: And quite an important one.

MRS. JONES: I think so.

DR. MACGREGOR: What are some of the things that, when you get back home, will be the very things you meant to take up here? [Pause] One that we heard from one family was, "Yes, but tomorrow morning will our boy get up on time and go to work?" This was a boy who had decided it was his mother's problem if he got to work on time. And at the last family-team conference, the mother asked that question. And we asked her to write and let us know. [Long pause]

MR. JONES: If he wanted to keep his job, I imagine he did get up.

DR. MACGREGOR: In fact, he's still got the job.

CHAPLAIN: I imagine if he wanted to keep mama he probably didn't.

DR. MACGREGOR: Well, that mother has decided to take a course in school in the next town, I believe.

MRS. JONES: If I had to go to work before they did, they'd just have to get out of bed on their own. I'm not supposed to do anything for them!

CHAPLAIN: Then who would be Mother?

MRS. JONES: Huh? I don't know. Let them worry about it.

PETER: Then Daddy could be Mother. Paul could be Daddy. That would be cool.

DR. MACGREGOR: I don't think he's got the aptitude for the job. I don't think he could learn it.

PETER: It would be kind of hard.

CHAPLAIN: There's only one person in your family that's got the gift to be a woman.

MRS. RITCHIE: Yes.

CHAPLAIN: I wonder if she'll be it.

DR. MACGREGOR: Your husband and son, while you were out of the picture, went ahead and bought another toy without full consultation with you. I have led right into a family problem here. Do these men have the authority to discuss fees with us?

MRS. JONES: I don't care what they do.

RESIDENT PSYCHIATRIST: What's all this?

PETER: Dad, let's go on a trip.

DR. MACGREGOR: Now it would be a sad outcome if the only result of this was that dad and son got close together in a way that excluded mother, whereas previously mother and son were close together in a way that excluded dad.

MR. JONES: I think that's quite definite. I agree with you.

PETER: That is the whole thing.

DR. MACGREGOR: I thought this might be a matter of concern. However, when I checked into it, I stopped feeling it was a matter

of concern. This man's interest is more in the adult world than in trying to fill his loneliness by building substitute relationships with kids.

MRS. RITCHIE: I can't help but feel some concern when I hear Mrs. Jones say, "I don't care." I [*Interrupted*]

MRS. JONES: That's the role I'm supposed to play, so I'm going to play it.

MRS. RITCHIE: That you don't care?

MRS. JONES: Their decision.

MR. JONES: Oh, not necessarily, Mother.

PETER: All you want to

CHAPLAIN: How would you like to see it work when you get home?

MR. JONES: Well, I'd like to see it work like we've all been saying that it should work.

CHAPLAIN: Tell her about it. How does it work?

MR. JONES: Pardon?

CHAPLAIN: Tell her how you think it should work.

MR. JONES: Well, that I should assume my responsibilities of being a father instead of letting her be the father and the mother too. That's what it amounts to, I guess. But not to exclude her, I mean, like what she said there.

RESIDENT PSYCHIATRIST: [*To Peter*] You said you'd tell her if he wouldn't.

PETER: Yes, where he asked her I said, "I'd tell her."

RESIDENT PSYCHIATRIST: Well, how would you put it?

PETER: Like he put it, that they should both share in the responsibilities of raising that little urchin over there as well as me; let Daddy do his part as well as Mother. I didn't mean for her to go home and say, "Well, I'm not going to do anything." Wouldn't last very long.

DR. SERRANO: That's very clear, isn't it?

MRS. JONES: Well, sharing responsibility is all right, but according to Dr. Y. [*the resident psychiatrist*] that isn't the business. It's not sharing. It's "Adolf Hitler *man*." [*Pointing to Mr. Jones*]

RESIDENT PSYCHIATRIST: I think you stretched that point just a little. [*Laughter*]

CHAPLAIN: I'd like to explain. This is the point at which Dr. Y. came in with all of his patterns, with both feet and all hands flailing. [*Laughter and comments*]

CHAPLAIN: She had been trying for half an hour to get me in that position, and I was shopping around keeping out of it and he came in and—pooh!

RESIDENT PSYCHIATRIST: I just walked in and got clobbered.

MRS. JONES: [*With good feeling*] I've already told them if you go home and change to the extent that they want you to and we break up and get a divorce over it, I'm going to sue, well, every one of you. [*Laughter and comments*]

DR. MACGREGOR: Well, I heard something that made me want to laugh when you said, "Well, now that was your—" you didn't use the word prescription—"to the letter." I got an idea that you listen to the sense of things and do what makes sense to you.

MRS. JONES: Well, I guess I do. I thought that's what we were supposed to do. What we thought was right.

DR. MACGREGOR: I would be surprised if you carried out Dr. Serrano's, Dr. MacGregor's, or Dr. Anybody's recommendations to the letter. All we can do is draw some diagrams that we've learned to apply to people we have known, and to you as well as we know you, but you folks have been living together for a lot longer than we've been living with you.

MRS. JONES: Well, just like I told him, I said, "If they have any questions for us, I want answers to go with the questions."

RESIDENT PSYCHIATRIST: We just told you the answer. [*In a friendly way*] Hard-headed!

MR. JONES: Well, Mother, I'm not figuring on going home and starting beating you, if that's what you think.

DR. SERRANO: [*Quietly referring to his review with Mrs. Jones of persisting fear of repeating early life experiences*] But you will find at home that your husband's attitudes will no longer be confused in your thoughts with your mother's controlling ways. It will be

Mr. Jones himself that you work things out with, not Mr. Jones plus shadowy figures from the past.

[*The conference ended a few minutes later on the following note.*]

DR. MACGREGOR: We do a certain amount of follow-up by visiting people and a certain amount here in the office. I can't say right now how things will be six months from now, but, of course, if we don't hear from you in that time, well, you'll hear from us anyway.

MRS. JONES: Well, that's a good deal.

DR. MACGREGOR: But I can't help but feel, as I was discussing with your husband, that if the relationship between you and him does involve some kind of durable change, everyone isn't going to be in favor of it and some will try to overthrow it. And this may seem to be quite a crisis. I'm more inclined to think that you folks should deal with this crisis when it comes up; that it'll mean so much more to you. I say, "Call on us in time of need," but I'd rather say, "Call us and tell us how you handled the crisis." Then if things look really chaotic, why, call us in. We would like to know that you have been able to settle the crisis yourselves by putting to work what you now know.

Post-session Discussion

After the family leaves, the team needs a brief conference together to release feelings and to "unwind." The intensive work over a two-day period has the advantage of cumulative impact on the family, but it is exhausting work for both therapists and patients.

Presumably all that needed to be said in the family's presence was said. In the team's post-session discussion the rationale for some aspects of strategy in the final conference may be explained, and the team members may exchange comments about their overall impressions of the family and the therapy.

At the end of the two-day work with the Jones family, for example, the team felt that the ease of getting started on the principal work at the MIT session was related to Mrs. Jones's attempts to

subvert the team's efforts because of her satisfaction with short-term goals: "Our boy has a job. I feel relief. Let well enough alone." This closely resembled Peter's participation in the intake session, which was limited almost exclusively to his campaign for a new motor scooter. The team agreed that this repetition of a theme had made clear at the outset of MIT a crucial pattern of value transmission in this family.

Lack of time and fatigue at this time prevented thoughtful dictation, which was scheduled for the following morning. Group dictation is described at the end of the next chapter, which presents a description and discussion of MIT.

CHAPTER 3

Description and Discussion of the Method

This chapter deals principally with method. Multiple impact therapy uses in combination the methods of individual and group therapy. The sessions follow each other in rapid succession in order to take advantage of the cumulative therapeutic effect. While therapists can bring to it methods with which they are comfortable and familiar, there is an orchestration of procedures unique to MIT and illustrated in the previous chapter, to be discussed here.

INTAKE

In this project, intake was not a screening step, but a planning step that performed a therapeutic as well as a diagnostic function. These conferences provided clues to the strengths and weaknesses of the family, and helped the team to determine a treatment plan suited to that particular family. They ensured that the treatment procedures were not only the product of expert advice but also of a group decision. They prepared the family for understanding of their part in the treatment and for the hard task of channeling constructively the emotional energy mobilized by the crisis the family faced. When the family considered a problem to be chronic and

without apparent crisis, the team then used the intake conference to highlight the critical aspects of the family's situation and to increase the discomfort in the family about their problem. An optimal level of tension is necessary to mobilize the family, to make them want to work on their problems, to evoke whatever self-rehabilitating force they may possess.

In a typical intake procedure, as in the Jones case, the referred patient and members of his family participated in a two-hour intake conference. If one of the team had known one or more family members earlier, or had been involved in the referral as Dr. Y. was with the Jones family, this team member introduced the family to the team and said enough of what he knew about the family problem to stimulate the family members to present their own ideas about their difficulties. The team members asked questions or made comments that not only helped clarify the family's problem but also started the family thinking about how it got itself in the mess it was in.

For example, in one intake interview, the parents expressed concern that their daughter repeatedly went to forbidden places such as public dances with undesirable companions, and that she tried to lie her way out of their accusations about this. The girl herself complained that her parents were unreasonable in their restrictions on her social activities, adding with little conviction, "I suppose it's for my own good." A team member asked how well the girl understood the reasons for her parents' restrictions. By this question the team member hoped to open the larger and more basic problem of inadequate and distorted communication within the family.

During an initial session, tentative formulations of the family's problem were made, and various diagnostic or therapeutic measures were suggested by either the team or the family—for example, psychological tests, medical procedures, or the use of drugs were sometimes discussed.

After this first team-family conference, each family member had an opportunity in individual session with a member of the team to

state how he saw the problem and what his suggestions were. Doubts could be expressed either by the therapist or by the patient about matters on which that same family member seemed to concur in the opening group situation. During these individual sessions the possibility of the two- or three-day family workshop was suggested, as well as use of any of the resources of the medical center or the home community.

The intake usually closed with another team-family conference, approximately the same length as the two foregoing sets of conferences. In the closing session, specific plans for MIT were proposed. If this was the plan agreed upon by the team and family, the team urged and instructed the family to utilize the period between intake and the date set for MIT to improve their self-observation, and to consider in the days ahead the dynamic patterns formulated at intake.

Intake, of course, varied according to the need for information. In the Jones family described in Chap. 2, considerable history had been taken by the referring resident physician who participated with the team at intake. Early in our experience with MIT we mistakenly assumed that explanation of MIT to the family by another clinic, hospital, or social agency was a sufficient intake procedure. In these earlier cases the family's first appointment in our clinic was for the two-day MIT. However, our experience indicated that the intake procedure should include members of the basic team and that, in fact, treatment starts with intake.

In four cases the work of reinforcing self-rehabilitating forces within the family was sufficiently under way during intake so that it was not necessary to use full-scale MIT procedures. Instead, those families were invited to return within two months for further exploration of their needs and to review family rehabilitative or regressive processes. One of these four cases is presented in Appendix A.

THE TWO-DAY PROCEDURES

The "briefing" session described in Chap. 2 was usually held immediately before the opening conference with the family. How-

ever, it is advisable for team members to review the referral information and intake notes a day or two in advance. In addition to the briefing session just before the start of MIT, a formal or informal team conference in advance of the MIT is recommended. In these early planning sessions we discussed various aspects of the case, shared speculations about the family, and made general plans for the treatment, including the size of the team and the use of auxiliary team members such as a chaplain, a community social worker, or a student or trainee. If a preliminary planning conference like this had been held about the Jones family, the hospital chaplain could have been invited earlier, rather than at the last minute. In most instances, of course, advance planning is absolutely essential in order to enlist auxiliary professional personnel.

In the briefing session, the team set initial objectives, sometimes diagramming them so that each therapist might have a clearer idea of the tactics of each team member and of the probable course of events when the team-family conference divided into smaller groups holding concurrent sessions. It is particularly useful when planning an overlapping interview to have some idea of where it fits into the work of others. The Jones family constellation was one of aggressive leadership by the mother, passive-aggressive functioning by the father, passive-dependent behavior of the younger child, and control through unpredictability exercised by Peter, the manifest patient. At the briefing conference on the Jones family this constellation was represented on the blackboard as in diagram A, Fig. 3-1.

An increase in leadership activity on the part of the father was clearly needed. This was represented by a dotted line labeled "1" on diagram B, Fig. 3-1. Increase in authoritative activity on the father's part could be expected to lead to a decrease in the mother's aggressive behavior, also shown on diagram B, Fig. 3-1, by a dotted line labeled "1."

When excessive or extreme functioning in reciprocal areas (aggressive, passive-aggressive, passive-dependent, or emotionally unstable) by parents is reduced, a healthier homeostasis or family balance will develop, leading to mobilization of rehabilitative and

MULTIPLE IMPACT THERAPY WITH FAMILIES

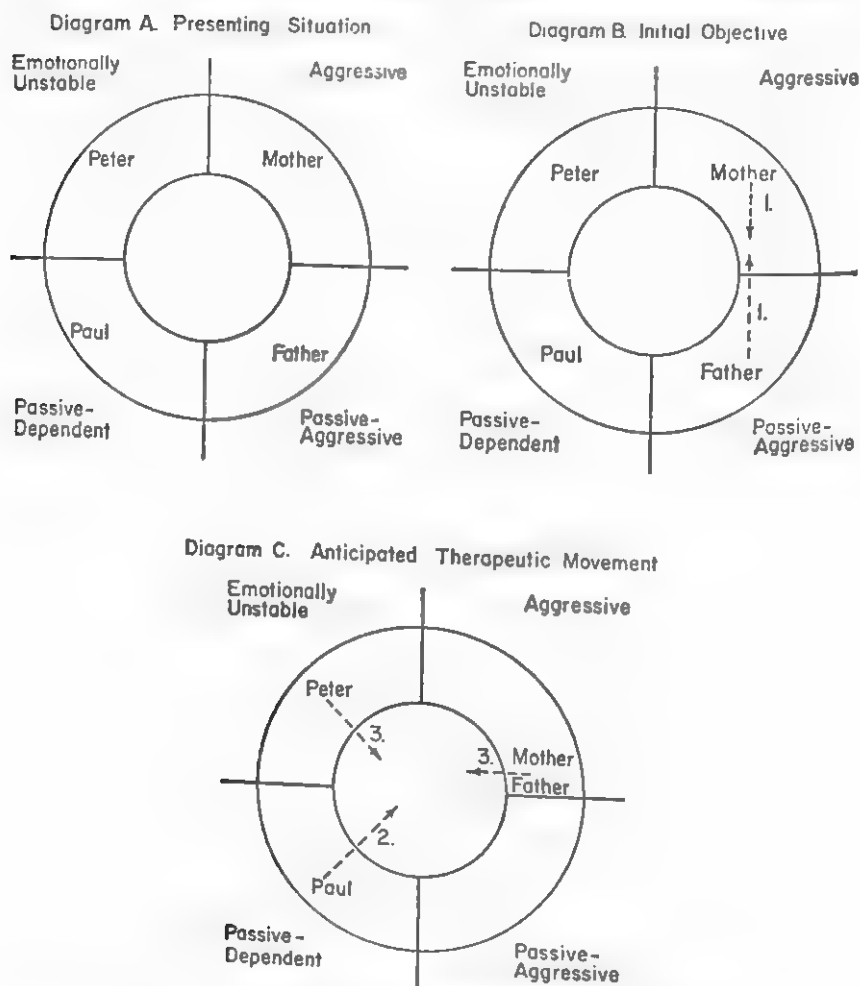


FIG. 3-1. Jones Family Constellation Diagrams.

growth processes for all family members, symbolized by the open center of the diagram. Thus, during the first morning's work with the Jones family, the team members began to see clearly Mrs. Jones's aggression expressed in a neurotic need to be of service to others, and her acting out of this need at her children's expense. The extreme immaturity and dependency of 9-year-old Paul could now be postulated as a result of his mother's overprotective attitude

toward him. The team then set, as a secondary objective, the freeing of Paul from the smothering attentions of his mother so that he could develop self-reliance and independence. (Represented in diagram C, Fig. 3-1, by dotted line "2.") A decrease in extremely immature functioning of several family members usually leads to an increased freedom and growth for all members.

Initial Family-Team Conference

In the intake conference, a few members of the family met a few members of the team, made an appointment, and perhaps got started on some new avenues of thinking and observing. In the initial team-family conference of the full MIT procedure, the family were confronted by a larger team with whom, as far as they could see, everything was to be talked out in the group. Some families dealt with this by reporting that their difficulties were so much improved that they had little about which to consult. When the Jones family returned, Mrs. Jones wanted to let therapy go because she felt so much relief during the previous two weeks, since her son had quit school and started to work. Other families gave broad hints that these difficulties had best be discussed in private. The team tried to make clear that such problems as communication were an important part of the work. After initial cordialities the family members were frequently reluctant to make a frank statement of their current problem. The team recognized and accepted the family's reluctance. In order to facilitate communication, a team member usually began by stating his personal formulation of the reasons the family sought help and of the dynamics of the family dilemma. We tried to do this in forthright, nontechnical language. For example, note Dr. MacGregor's comments in the opening conference with the Jones family. "Well, I want to talk a little more about the uncomfortable implications of the position that Peter has occupied in the home. . . ." [To Mr. Jones] "I'm wondering if Peter has more to say about what your wife does than you do. Peter seems determined to run the whole show." If such a comment did not stimulate expression by the family of ideas,

facts, or feelings, team members may demonstrate the way in which the family might respond, or a team member may have risen to the defense of the family member who seemed to be placed in an unfavorable light.

The conference usually lasted about an hour, by which time tension was sufficiently mobilized to give considerable release value to the individual interviews which followed.

Individual Interviews

Unless some change in the plan made in the briefing session was openly discussed in the team-family conference, each member of the basic team invited his previously agreed upon patient to his office and perhaps invited a trainee or community representative to join them. A family member who felt he had appeared less than creditable may have had considerable need to have someone understand why he behaved as he did in the family conference. In the individual session he got the support he needed and the therapist obtained the information necessary to prepare himself for later interviews with other family members.

Typically, the interview with the adolescent was briefer than the concurrent ones with other family members. Several reasons accounted for this. The attention span of adolescents tends to be shorter than that of adults, and tremendous physical energy makes it difficult for youngsters to tolerate the interview situation for prolonged periods. Moreover, sometimes shorter interview sessions and occasional periods spent by the child or adolescent in the waiting room or playroom were deliberately planned to demonstrate the team's interest and concern for other family members as well as for the nominal patient, who had been perhaps too much a focus of interest in his home or community. The shorter interview with one patient also provides an opportunity for an overlapping interview, as described below.

In about half an hour, the therapist got the idea of what the youth's strategy had been. He then conveyed to the boy or girl his comprehension that the behavior about which there was complaint

was an understandable response to the situation. The therapist also may have given the impression that although the youth imagined that he had been having his own way, he may have been used unwittingly to meet the needs of others, at some expense to himself.

The therapist often terminated this interview by telephoning the office of another team member and, if invited, he left the adolescent with a co-worker or in the waiting room and joined or "overlapped" a parent's session.

Overlapping Interviews

An important aspect of MIT has been the overlapping interview [1], which is used extensively and flexibly throughout the two-day procedures, and which may be a part of the intake and follow-up sessions. The overlapping interview has offered unusually good opportunities for communication within the family, between team and family, and within the team during the actual clinical work. The outstanding feature of the overlapping interview is the summary given by the therapist to the incoming team member of what has gone on so far in that interview. This review not only informs the visiting therapist of the content and progress of the session, but also conveys to the patient the therapist's comprehension of the patient's statements and feelings.

The summary provides an opportunity for making some interpretations in an indirect way, both by the selection of material to be reported and by the way this material is presented. The therapist encourages the patient to correct or supplement the summary, thus denying any pretense of infallibility and figuratively reiterating to the patient, "This is a team endeavor and you are part of the team." The incoming therapist responds to the summary by attempting to relate it to the information or impressions gained from other family members [2]. This again is aimed at facilitating understanding and communication within the family.

The use of overlap technique helps to keep clear the dynamic themes that need to be the foci of the work. In other words, the

therapists repeat, not only to each other but to family members, the definition of the problems and the significant aspects of family interaction that have contributed to these problems.

In the Jones case, there were more than the usual number of overlapping interviews because of the comparatively large team that included four trainees who participated primarily for the learning experience. Dr. Serrano, now ready to study the youth's part in the family interaction, joined Mr. T., the psychology resident, whose assignment had been to observe Peter. Dr. MacGregor's objective in leaving the conference with Mr. Jones to join in the interview with Mrs. Ritchie and Mrs. Jones was to attempt to open channels for mutual understanding and communication between the parents.

Team's Luncheon Conference

The midday team conference on each day of MIT has been an important and even essential part of the procedure. During the work with the Jones family, as in most of the cases of the series, one and one-half to two hours were set aside on the first day; and two to two and one-half hours on the second day. During these midday breaks the families had lunch at a café of their choice and sometimes went shopping or sight-seeing. On the first day, the team and at least one consultant met for lunch, usually at the faculty cafeteria or occasionally at an uncrowded restaurant where a secluded table was available, and the conference was held at the table during and after the meal. On the second day the team frequently had lunch together, although this was less essential because the regular weekly meeting of the clinic staff and supervisors was held at 1:00 P.M.; appointments with the families were planned to take advantage of the scheduled staff meetings.

The luncheon break provided the team with an opportunity to share information and to plan next steps, and it also provided an opportunity for reduction of tension by ventilating feelings. From the study of the reactions of team members to the family and the ways in which various team members have allowed themselves to

become involved with individual family members, we may learn more about the characteristics of the family and reduce the possibility of inadvertent distortions on the part of individual therapists. This kind of check on the attitude of therapists permits the team to allow themselves involvement in the material with minimum danger to the patient from countertransference or lack of experience.

Multiple Interactions

It was usual for each parent to start the first afternoon session with an interviewer who in the morning had spent some time with the other parent; the morning interview with one parent provided background for the afternoon session with the spouse. The nominal patient and his siblings were given psychological tests or other diagnostic procedures. Discussion with the parents of their concern for the youngsters was deferred on the grounds that the family and its members were still being studied diagnostically. Thus each parent was helped to give more attention to his own problems. The sessions in the early part of the afternoon often yielded crucial data which were correlated in joint interviews or team-parents conference later in the day.

Reconvened Family-Team Conference

A family-team conference at the end of the first day's work was to take full advantage of family processes. Whereas the family members in individual or multiple-therapist situations may have maintained a resistive attitude toward team members, the family now faced each other as well as team members, and by openly telling of revised attitudes about the family and its situation, the team provided a climate for change. This was often furthered by a therapist's accepting from others, or offering as self-criticism, information on the way his own involvement in the situation interfered with understanding, and how he had changed his ideas.

The more resistive parent sensed that he was not getting the former familiar reciprocal response as he reaffirmed his resistive

attitude. His once antagonizing gesture now lacked impact on the family as a result of the day's study. The family was disturbed by the anticipation of the forthcoming evening that would be spent together. Family members sensed that their former barriers to intimacy might not serve quite so well and felt anxious at relinquishing their protective façades.

In the early cases of the series, the team recommended to the families that during the luncheon break and on the evening after the first day they discuss among themselves their feelings and ideas about the work with the team. Experience with several families indicated that one family member sometimes used this recommendation in a controlling or threatening way that mobilized the resistance of other family members to genuine involvement in the therapy. From these experiences the team learned how difficult it is for families at this stage to discuss among themselves their attitudes toward changing the balance of forces in the family. The impact of the day's experiences usually stimulated as much discussion within the family as its members could tolerate. Pressure from the team to do more seemed to increase resistance.

Second Day Procedures: Morning

In the brief opening team-family conference, the family usually reported on events and activities of the previous evening. This report provided the team with a basis for evaluating any changes in ways of communicating or relating within the family. When the family did not offer such information spontaneously, the team asked for it. The kinds of intrafamily communication that took place, or barriers to communication if no significant discussion occurred, were briefly discussed.

Opportunity for intensive work with the member of the family who was most threatened by the first day's developments was important in planning the second day. The brief opening conference gave an opportunity to confirm or revise ideas as to which member would suffer most by changes in the attitudes and behavior of

other family members. Indeed, we have found that the ability of a family member to assume more appropriate attitudes and roles is an early and important clue to his readiness to participate actively in family rehabilitation. The one whose position was most threatened was the one with the least flexibility, e.g., the one who could direct others but could not give way to change. This was usually a parent, although occasionally a very sick child or adolescent seemed to be even more rigidly bound by pathological patterns of relating to others than were his parents. When necessary, the day could be organized around longer sessions for this person. The therapist selected for him was one toward whom the family member had shown a significant response the previous day. Or the therapist for a disturbed patient was chosen according to whether the patient's needs were best fostered by a man or a woman therapist. This usually depended on whether the patient achieved satisfactory recognition from his parent of the same or of the opposite sex.

Moreover, considerable attention was needed by the seemingly "well" sibling, who often seemed to deal adequately with the family situation, but did so at considerable cost to the development of his own potential [3].

Frequently, the nominal patient and one of the parents or siblings were encouraged to use each other as consultants during the second day. This was one of the goals of the private session between Peter and his father in the morning and of Mrs. Ritchie's session with Peter and Paul together in the afternoon.

Second Day Procedures: Afternoon

As indicated earlier, the noon break on the second day was longer than on the first day to allow the team members time for lunch before the staff meeting where they met with consultants. Together, they reappraised the situation and progress of the work with the family, and made sure that there was agreement among team members about the diagnostic evaluation and any recommendations to be made to the family.

Interestingly, we regularly found that the family members also utilized the time for reappraising their situation and the progress of the work with the team.

Apparently, their realization that there were only a few hours left tended to increase their wish to make constructive use of the remaining time. The team postponed discussion of specific "back-home" problems until the final sessions. Where the work had gone well, the family often proposed their own answers to their earlier questions, finding those answers in what they had learned of their own habitual patterns of behaving and interacting and their awareness of alternative patterns that might be tried. In the final family-team conference, when a member of the family or of the team suggested an early follow-up appointment with the MIT staff to check on the answers the family had proposed to its own problems, the staff usually refused. They told the family that such an early return appointment would be contrary to the respect the team had gained for the family's ability to deal with situations as they arose. The family was told to expect crises in which one family member tested out the new attitude of the family. We frequently recommended to a family that they study the way they dealt with these crises, and we urged them to let us know what happened. We usually suggested that they seek our help only after they had spent 24 to 48 hours attempting to deal with post-MIT crises on their own.

In the final family-team conference, the work of the two days of MIT was reviewed in terms of its applicability to the practical situation to which the family would return. By this time the relevant recurring patterns of troublesome family interaction tended to be clear to various family members. The family was urged to be vigilant to the recurrence of these troublesome patterns and to view them as warning signals—signals that should set the family to work to devise a sound solution to a crisis. The work of the two days was looked at in terms of the practical situation to which they must return.

Although by the second day of MIT there was usually a con-

vergence of opinion among team members as to the basic difficulty of the family and the measures needed to correct it, members tended also to view the family dynamics from different points of view according to the discipline in which each member was trained. The psychiatrist, who used understanding of the early life situations of the parents as his approach, on several occasions reminded an uncertain patient that the situation to which he was to return would be clearer because he could deal with people as they were, rather than in terms of figures of the past. Dr. Serrano's review of Mrs. Jones's excessive conformity to her own mother's severe control is an example.

The team member who emphasized the group dynamics approach frequently used an event in the therapeutic session to show how old patterns of behavior could no longer pay off because they were contrary to the revised goals of the family. In our team, this was usually the function of the psychologist, Dr. MacGregor. In the Jones case, the chaplain performed this function on at least one occasion, when he and Mrs. Jones saw then and there that she was re-enacting her pattern of belittling men.

The social worker often focused on objective facts and reality situations that the family and its members would have to face on returning home. In the Jones case, Mrs. Ritchie focused on the fact that although Paul was of normal intelligence and easily capable of doing third-grade work, he was failing in school primarily because his mother was doing his homework assignments. Mrs. Ritchie also reminded Peter and his family that operating a motor vehicle without a license could lead to revocation of Peter's parole from the state training school.

GROUP DICTATION

We found it useful for several purposes for the team as a group to dictate a case report within a day after the family left. Duplication of reports was eliminated and accuracy was improved by the same "cross monitoring" we had found useful in treatment. The bias of any one team member was corrected by colleagues. The

review of technique also served a training function. Coordination was achieved for such matters as reports to referring sources, billing, and agreements made with families about future contacts. From the research standpoint we had a continued review, testing, and discussion of hypotheses under investigation.

At a minimum, the record included a case summary, sometimes supplemented by a session-by-session résumé of the therapy.

If the group dictation was delayed for several days or longer after the family left, it was useful for the team members to refresh their memories by dictating a sentence or two summarizing the content and process of the sessions in which they participated in the order in which the sessions occurred. The flow chart, Fig. 2-1, kept by the clinic secretary was a useful guide for dictating the process report. This résumé enriched the subsequent group summary. We also found it useful as a teaching instrument, and it could serve as a guide or road map for following the tape recording of an entire MIT.

The case summary was dictated according to an outline [4]. Before dictating each section, the team discussed the reason for the item in the outline, and the kind of material from other cases which had been dictated under this heading. Then the material from the case at hand was discussed. When a consensus was reached on each point, the person who worded it aptly was handed the microphone to dictate the entry.

The summary included a review of the case at the end of MIT and a comparison with the status of the case at intake, as well as an analysis of the family dynamics in such a form as to indicate what should be looked for at follow-up.

FOLLOW-UP

In all cases the families were informed that for research purposes the team would communicate with them by letter after 6 months to arrange appointments for follow-up interviews, either in the clinic or in the family's home community. We expected that follow-up interviews would be impossible or impractical in some

families because of various factors such as a family's moving to another state, an older adolescent patient's marriage or entry into military service, breakup of a family by death or divorce, or a family's resistance or hostility to the team.

The research design called for 6 months and 18 months follow-up evaluation by interview on one-half the families, and as the appropriate families could not be selected in advance, all families were told of this plan in the hope that at least half of them would participate in the follow-up evaluation, which they did.

The evaluation follow-up interviews with the families were used for additional therapy as well as for research purposes. Supplementary appointments were made with many families for additional therapy. As indicated earlier in this chapter, during the final family-team conference of the MIT the patients were assured that emergency return appointments could be arranged if needed.

In addition to routine follow-up interviews and emergency appointments, at the close of MIT in some cases the families were scheduled to return to the clinic for additional therapy at bi-monthly or occasionally at monthly intervals for periods of 6 to 12 months.

Follow-up sessions usually lasted two to three hours. In contrast to usual or scheduled follow-up, emergency appointments requested by the family because of a crisis usually required a full day or even longer. Both the therapeutic and research follow-up visits included group and individual sessions.

The team for follow-up work was frequently smaller than the expanded team engaged in MIT. This was primarily because of practical limitations of time, and, in the case of follow-up visits to the homes of families in other communities, the expense involved. Ordinarily, the team for follow-up included the basic three-member team of psychologist, psychiatrist, and social worker. On a few occasions, one of the project directors or a medical or psychiatric consultant participated in a routine follow-up, because of a special interest in the project or the family. When a psychological test was to be given to any family member, a psychology resident was added

to the team. On field trips, in addition to administering psychological tests, the resident gained experience in observing families and in establishing and utilizing community contacts. Occasionally he went to a nearby school to test a child or adolescent patient, while the basic team remained with the parents. Field follow-up visits were usually conducted in the family home, but we have also used a hotel suite, and on two occasions the referring social agency arranged to provide an office for interviewing. With the patient's permission, we have also visited schools, local physicians, law-enforcement agencies, and places of business for personal contact with referring persons and significant community representatives.

Field trips were organized in a circuit so that five or six families could be seen in a week on one trip. Each family was given several weeks advance notice that we would be in the area, and a definite appointment was set for the follow-up visit. With only two exceptions, the families were warmly hospitable regardless of their socioeconomic level. The team avoided having meals with the families. The home visits provided an excellent opportunity to gather cultural data and enhance our understanding of the families and their communities, and if the numerous invitations to stay for lunch or for dinner had been accepted, this aspect of our study would have been richer. However, the individual members of the team felt that they would be uncomfortable in the role of guest at a table presided over by a patient as the host, and that this discomfort would interfere with, or even entirely prevent, fulfillment of the objectives of the visit.

The primary objectives were to secure information essential for evaluating the efficacy of the MIT with the family and to provide additional therapy if needed to facilitate the rehabilitation of the family. Our usual reply to invitations to meals was, "Have a pot of coffee on the back of the stove for us."

The team prepared for the follow-up by a briefing session. This was held in the office if the family was returning to the clinic, or on a field trip the briefing session occurred in the automobile on

the way to the patient's home. Team members reviewed and discussed the case summary and current correspondence. The diagrams of family constellation that were illustrated earlier in this chapter (Fig. 3-1) were also discussed.

When the team arrived at the home the youngsters, who were already acquainted with our use of tape recorders, were asked to carry the equipment into the home. While the discussion was getting started, one team member worked with the youngsters, requesting their help in setting up the equipment. In a short family-team session the interim events and current situation were recounted by family members, and there was usually some recent correspondence to alert the team to the problem areas. The briefing session had prepared team members to explore aspects of the family situation where change was anticipated or needed. The nominal patient was then usually seen privately by a psychology resident for testing or by a basic team member. This interview was usually held in the adolescent's own room if he had one. Otherwise, he was asked to suggest a suitable place, which sometimes was the kitchen or porch, or occasionally even a walk outdoors. On home visits, typically, the parents were interviewed together by the rest of the team, although occasionally they, too, were seen separately. Other children in the home were usually present when the team arrived but were later excused by their parents. Occasionally the social worker requested them to show her the garden, or the farm, or the immediate neighborhood, in order to provide the parents with an opportunity to talk more freely with a therapist.

Follow-up, like intake, is a therapeutic step and should be considered a part of the MIT procedures. It is intended to supplement the earlier therapy and to reinforce and extend any rehabilitation that may have occurred. The therapeutic tasks at follow-up may include supporting the father's new and sometimes awkward efforts to exercise more leadership in family matters, or helping the mother to appreciate her husband's leadership and renewed interest in her. In some cases, the team helped the mother to deal with guilt

feelings about enjoying her new-found freedom from excessive dedication to her child. In other families, the therapeutic work at follow-up was directed toward helping the parents to accept their youngster's social and emotional maturation, and to feel pride rather than insult and depression when the son or daughter showed ability to have constructive relationships with peers and adults outside the home.

The Adolescents and their Families

The referral diagnoses, particularly those such as adolescent maladjustment, sociopathy, behavior disorder, and juvenile delinquency, failed to differentiate usefully among the cases, as is often true with psychiatric nomenclature. The team's analysis of its clinical reports revealed four family patterns, each associated with arrest at a different stage in development, manifested by a youth in the family [1]. We were able to classify all the 62 patient families within four syndromes. The syndromes, labeled in terms of the developmental problems of the youth, are as follows:

- Type A.* Families presenting infantile functioning in adolescence, the six schizophrenic adolescents
- Type B.* Families presenting childish functioning in adolescence and preadolescence, the autocrats
- Type C.* Families presenting juvenile functioning in adolescence, the intimidated youth
- Type D.* Families presenting preadolescent functioning in adolescence, the rebels

The levels of arrest described and the associated developmental tasks are derived from developmental epochs described by H. S.

Sullivan [2] and E. H. Erikson [3]. The description of each syndrome appears to indicate a different therapeutic task and may have implications for other programs aimed at the welfare of youth.

Present theories are useful, for example, in accounting for the prevalence of juvenile delinquency. They tend, however, to view the teen-age response to the influence they describe as though it were a fairly uniform group of behavior patterns developmentally preadolescent and adolescent. Appropriately, treatment and control measures have counted heavily on the ability of these youngsters to be enlisted in group activities and to identify with more satisfactory models. Suggested family approaches in suburbia have been directed at supplementing the family's waning ability to negotiate a place for its youth with agencies that appeal to these same preadolescent attributes [4].

It has been the observation of the multiple impact therapy project staff that the pathological behavior observed in youth of each of four types of families has as its goal relief from a problem appropriate to a level of socialization beyond which the family was not able to help the child. In only one of these patterns had this level reached preadolescent functioning.

While it is true that delinquency comes to the attention of authorities in common pathways such as running away, stealing, and vandalism, it appeared among the youth we studied that similar behavior in different youngsters may have different goals. One runaway may have emancipation as its goal; another may be part of an effort to be dealt with by authority which exercises more restraining controls. Still another seeks approval of a more adolescent leader. Other runaways may represent an inability to grant leadership to anyone, or possibly a deeper disturbance in basic trust.

Early diagnosis in terms of these four patterns of family functioning brought about better coordination of teamwork. At the briefing session that preceded the two days of multiple interaction therapy it was possible for the several therapists to make some over-all therapeutic plans, and for each to have in mind something

of the direction of work going on in other offices during concurrent sessions.

When the behavior associated with each type, as it unfolded in family-team work, became more clearly specified, earlier identification of the patterns became possible.

The briefer multiple interaction procedure used at intake to engage the family in the therapeutic process has thus increased in diagnostic value. It shows promise as an examining procedure for research and for clinical study of family situations. Such a brief study of the Dyal family appears as Appendix A.

The health of the family as a social organism can be viewed in terms of the conditions which promote the growth of its members, and hence their ability to adjust and contribute to the solution of new problems. Since all are not identically endowed with ability, experience, and circumstances, a division of function occurs which differs from family to family but which tends to stay within the pattern for the particular subculture.

The family provides the setting within which the individual becomes a person. It helps to make the young ready for experiences outside its fold, and to meet the survival needs of all its members. Provision for the young from early passive dependency through eventual emancipation yields some maturing satisfaction for the adult members. The family, however, cannot meet all the needs of any individual. Each family member needs a variety of other environmental stimuli from outside the family. It is the special ability of living systems to select from what the environment offers that accounts for growth. The family is called upon to provide its adult members as well as its youth with opportunity for relationship, self-expression, and experiences that contribute to their continuing growth. If members are deprived of outside stimuli for long periods, their ability to adapt suffers. Deprivation occurs when families or individuals in them are largely on the defensive. External influence becomes unwelcome and the family operates as a relatively closed system.

In such a troubled family, its ability to scan external reality

suffers. Its communication system then is used to discourage interruptions of the internal equilibrium. When functioning in such an internal state, the family, an individual, or any system expends but does not acquire new material and gradually deteriorates. A self-rehabilitative possibility appears when one child's function becomes that of externalizing—unwittingly betraying—the unresolved and otherwise unexpressed parental conflict.

The division of roles within those families presenting immature adolescents was characterized by inflexibility, which appeared to be a defense against feelings of inferiority. The youth and other members of the families seemed to behave as though forced to sacrifice growth possibilities in order to continue indefinitely to perform in a particular role. This seemed to result from a breakdown in the family's ability to provide its members with new experiences, love, and approval, the stuff which gives nurture to creativity. The effect on morale of family members is seen in doubts about adequacy and in their feelings of inferiority about what they have to offer. This may be associated with irrational fear of having too little influence to guarantee survival. In such situations of emotional scarcity, inflexibility appears in the system and is manifested by defense of current power position within the structure and exploitation of other members for release of tensions ordinarily gratified in constructive contact with the outside. The more inflexible, relatively closed division-of-function system results. The neurotic family substitutes power and collusion for the more tender values associated with trust. Bowen, working with hospitalized families, observed reduced flexibility in his families in the presence of exploitation of the child.

The striking observation was that when the parents were emotionally close, more invested in each other than either was in the patient, the patient improved. When either parent became more emotionally invested in the patient than in the other parent, the patient immediately and automatically regressed. When the parents were emotionally close they could do no wrong in their "management" of the patient. The patient responded well to firmness, permissiveness, pun-

ishment, "talking it out," or any other management approach. When the parents were "emotionally divorced," all "management approaches" were equally unsuccessful [5].

Examples of various ways of expressing influence in the family are familiar from studies of sibling position. As cited by A. F. Henry [6], in our culture the mother first assumes responsibility for the care of the child. As the child grows older, the father shares increasingly in his nurture and discipline. With the arrival of a new baby, the mother is again forced to concentrate her attention on the infant. This shifts the burden of discipline of the older child to the father. Then the newest arrival in the family grows to perceive the mother as the principal disciplinarian. In the situation of poor morale, the older child may combat his feelings of unimportance by developing an importance as a nuisance or a scapegoat. Such a conception of the division of functions and roles among family members helps explain why siblings have quite different life experiences and personalities. Selection of the particular child to occupy the position which Vogel and Bell [7] designate as "the family scapegoat" seemed related to various factors such as response of the family to the birth of a child of a certain sex or constitution; to environmental stress, sibling position, illness, or physical handicap. Similar factors were reported by Lindt and Goldman [8] to be associated with the particular child in the family who developed asthma. The neurotic equilibrium of the family is broken down when the adolescent's behavior becomes unendurable to himself, the family, or society. This precipitates a crisis that tends to mobilize the family to seek some type of help. It is at this time that a clear understanding of adolescent maladjustment and family dynamics becomes most important for diagnostic and therapeutic purposes.

For each family syndrome we present a case report which was prepared from our research outline. The manner of exploitation, relationship to authority and peers, matters of aptitude, and the division of functions within the family are presented. Then these topics are discussed with reference to all the families of that type.

The family constellation typical for each syndrome is illustrated with a diagram.

THE REBEL AND HIS FAMILY

The relationships within the family which yield rebellious behavior, preadolescent functioning in adolescence, are significantly different from those which were expressed by the childish functioning of the 15-year-old Peter Jones as illustrated in Chap. 2. The *rebel* and his family relationships are illustrated in the following study of Rocky Cramer and his family.

Mrs. Cramer, who was obese but still showed evidence of having once been a rather pretty girl, expressed with desperation to the team the complaint that her 17-year-old son, Rocky, was spending so much time with his girl friend Kathy that sexual intimacy and pregnancy might disrupt all of their lives. Kathy lived in a nearby town, and Rocky visited her or telephoned her at least once every day. Mrs. Cramer added, "This girl is pretty but not prettier than I am, and I've got lots more than she has." Her grievances ran on, monopolizing the conversation. She showed little difference in affect between her complaints of Rocky's excessive use of the family car, his too frequent long-distance calls, his distaste for shirts she buys, and complaints of her own history of physical ailments and treatment including hospitalization by a series of internists and psychiatrists. All her complaints were augmented by "nervousness" for which she blamed her family, which included three sons, John, Rocky, and Bill.

Rocky, the nominal patient, a tall, pale young man, draped himself on the end of a couch in an ostentatiously relaxed posture and wore a wry smile. He occasionally asked with sarcastic patience, "Have you finished?" or "May I speak?" Then he offered a reinterpretation of his mother's remarks, ending with a kind of hopeless unfinished sentence which was itself a dramatic gesture. He complained that it was useless to attempt to voice his views in the family because his parents would not listen. He agreed that his temper tantrums over such matters as shirts did bother him, but that any visit to a clinic such as this one would be useless because his parents would talk and not listen. If they listened, he said, they would not use the advice.

Mr. Cramer, a foreman for a small manufacturing company, gave the appearance of a clerical worker in his somewhat worn business suit and dark tie. An attitude of hurt dignity pervaded his manner. He

seemed to be supporting his wife's complaints but he had little information about what he was supporting. He tended to sidestep direct questions and to minimize matters presented by others as crises. He said that he had been left out from discussion of these issues. He blamed himself for not participating fully in the handling of family problems and regretted that his son never talked to him. He was quite personable in appearance, and he warmed a bit as he spoke of his community activities. He had been re-elected to a second term on the school board and was active in service clubs.

Typically, his wife made her style of control apparent first by showing a patronizing attitude toward his achievements, and then by showing her contempt for his need of them. She showed patronage by telling of her efforts to persuade Rocky to remain active in school athletics to please his father. She had reminded her son that Father, who had little education, was very much interested in the success of the school teams. She then went on bitterly to complain that while her husband's involvement in the school board and service clubs may have added to his prestige among the men, it resulted in neglect of her. When a team member suggested that she must have had a way of being more attractive to him before, she seemed to disparage his manhood with, "Well, if you want to put it that way, I have to ask him."

The mother's inability to allow the men in her life any self-determination had a background in the teachings of her recently deceased mother, that men were interested only in sex and in exploitation of women. This had been reinforced by her memory that her father had been harsh and neglectful toward her mother who "had to fight for every bit of religion that she could get for herself and the children." At the age of 15, to get away from this unhappy home, she had married John Blanc, a 22-year-old man who proved to be like her father: self-indulgent, immature, abusive, and neglectful of her while having affairs with other women. This first husband, the son of overindulgent parents, refused to move away from his parents' home, where he was the spoiled darling and his wife was the unwelcome but tolerated intruder. He denied paternity of Rocky, their second child. He left the hospital when his wife was admitted in labor without any evidence of concern about her welfare or the safe delivery or sex of the child, and during his infrequent calls at the hospital during the next ten days, he seemed more interested in flirting with the nurses than visiting his wife. No resolution of their problems had been reached when he went off to war and was killed.

Mrs. Cramer took no chances on being at her husband's mercy in

her present marriage. Mr. Cramer had been traveling with a minor-league football team and had started drinking heavily when he took an interest in the patient's mother. Her terms were that he stop drinking and secure regular local employment if he wanted to court her. Shortly after the marriage their son Bill was born. About eight years later Mr. Cramer took instruction and became a convert to his wife's religion. Mrs. Cramer managed his pay check and most executive functions about the home, while her husband rose to a position of responsibility with a manufacturing firm in their community.

It was to her eldest son, John, that this mother had turned for emotional support. In John's first five years of life he had developed the special closeness often found between son and mother where a father was away in military service during the child's infancy. This closeness developed and continued in spite of the fact that Mrs. Cramer (unlike Mrs. Jones) had to work, and her two sons by Mr. Blanc were frequently in the care of relatives, usually the paternal or maternal grandmother. Indeed, the prolonged symbiotic relationship between John and his mother continued after the mother's marriage to Mr. Cramer and the birth of their son Bill when John was 6 years old.

Not until John was in high school did he begin to relate constructively with and identify with his father. At that time Mr. Cramer invited John to help him make some repairs to the home, and about the same time Mr. Cramer began to require the three boys to assume more responsibility for chores than before. The following summer he helped John to find a summer job. This new relationship between John and his father developed during a time when Mrs. Cramer was suffering from fatigue, irritability, temper tantrums, and other depressive symptoms following a hysterectomy.

John was an excessively "good" boy, but was unable to make friends among his age-mates. With surprising naïveté he told the team that he had become more his mother's confidential adviser than was her second husband. Mrs. Cramer appreciated her son's dedicating himself to her and their mutually absorbing relationship apparently freed the other family members from exploitation by the mother. During John's entire lifetime his relationship with his mother had been so close that she was unable to see his pathological condition, even when he was unable to stay away from home overnight, or later when he rushed home in homosexual panic during his freshman year in college.

Rocky, the nominal patient, resorted to devices very different from those of John to ensure his own importance. Wherever John failed, Rocky succeeded. He won school recognition by academic and athletic

success, and was twice president of his class. As a preadolescent he was a fairly anxious child with a neurotic concern about masturbation. His character development showed passive-aggressive trends manifested by a cool, detached way of analyzing the arguments of others and trapping them with their own logic. He knew his father as a kindred soul, isolated from the rest of the family, and an easier object of identification than the same father whom John had perceived for so long as a disapproving rival.

Rocky, too, was somewhat isolated from age-mates because he would engage only in those competitive activities in which he excelled. To achieve skill in baseball, for example, he first allied himself with older boys by whom his inferiority was accepted because of his age and size. In high school Rocky became a leader in adult-sponsored activities such as organized school sports. His leadership resulted largely from his value to the teams, but also it undoubtedly was due in part to his father's prestige as a member of the school board.

When John went away to college, Mother turned her consuming attentions on to Rocky. This second son had no background of prolonged sympathetic symbiosis, and reacted strongly to the insult to his individuality. To her, his successes were not his own. It was obedience to her that accounted for Rocky's having gone out for school sports. His successes in having articles about the school published by several local newspapers she considered to be an aspect of her control. The boy grew to resent his father's prominence in the community. He refused to re-enter school, demanding that he be sent to a private school in another town where his father's influence could not be considered to account for his success.

Mrs. Cramer focused particularly on Rocky's having a girl friend as the root of all the family difficulties. Rocky had never been able to develop a real chum relationship with any particular boy, but found some safety in having a "girl friend in the next town." Our nominal patient was shy about becoming intimate with anyone lest his shortcomings be appraised, but he now felt forced into the defense of this friendly rather than amorous relationship. Kathy became his chum. Kathy's mother expressed hope that it would be more than that, and scorned Mrs. Cramer's interference.

Rocky betrayed fears of inadequacy when he reported being troubled by occasional show of seminal fluids and by nocturnal emissions. In contrast, his parents, who had also noticed, took this to be evidence of heterosexual excesses. Rocky, personally ill suited to the rebellious, aggressive role, took the rebellious route. Dramatic gestures of despair at

the possibility of parents' understanding—styled after Mother's hysterical maneuvers—were used in response to prying questions. Late hours with the girl friend, long-distance phone calls, and the irresponsible use of the family car expressed the conflict between his desire for individual identity and his desire for prolonged adult supervision. The temper tantrums were frightening to himself and his family. The marriage that both he and his family feared seemed to be the only way out. In the background of the parents' overreaction was the partially suppressed fact that their youngest child, Bill, had been conceived before their marriage.

Mrs. Cramer had needed and worked for her husband's respectability (and therefore indirectly her own) to the extent that she made it a family project not to make demands that might interfere with Father's social career. Now she acted as though his career were hers to destroy. She resented his prestige in the community and his influence on the children. Mr. Cramer's feelings were especially hurt by the "silence treatment" he received from Rocky, once his pride and joy. In this family turmoil the youngest son, Bill, became even more conforming than he had been, but his nail biting increased and his sociability decreased.

Significant communication in the home was minimal and indirect. While each family member could talk easily and well with others in the community, nothing of importance could be discussed at home. To "listen to" one another was equated in this family with "submitting to the control of" the other. Members of the family learned of each other's attitude through third parties. For example, Mrs. Cramer ventilated her concerns about Rocky to her pastor, who was Rocky's confidant. She did this apparently less in the quest for spiritual counseling than in the hope of securing information about her son. It was finally the pastor who reinforced a physician's recommendation for psychiatric help and referred the family to our clinic.

Such preadolescent functioning in adolescence is represented by a group of 20 teen-agers, most of them age 16; nine were female. These youngsters were referred because of rebellious and delinquent behavior of recent onset (within the past two years). They demanded the privileges of young adulthood. At the same time they frightened their parents by the way they showed disregard for the responsibilities that go with those privileges. It was clearly impossible to grant them privileges appropriate to their age.

Relation to Authority

This group was ambivalent about authority but certainly fascinated by it. The misbehavior of these youngsters appeared at times deliberately calculated to require parental and community disapproval as well as firmer and more consistent discipline.

Scott Glamis, a 16-year-old boy, was charged with three offenses of "robbery by firearms," a capital crime in Texas. Before these recent episodes he had come to the attention of the juvenile authorities for less serious matters including runaways, curfew violations, and attempted theft of phonograph records from a supermarket. He had been expelled from school for setting fire to a wastebasket in the washroom. The probation officer, who regularly found Scott quite cooperative, recommended to the family that they consult a psychiatrist in their city, who referred the lad to a Medical Branch psychiatrist for hospitalization. It seemed to the hospital psychiatrist that the adolescent sought the more definite and protective authority of the courts in preference to the vague and contradictory authority of the family where conformity and nonconformity were advocated by his mother and father respectively.

The kind of rebellious behavior that these patients exhibited appeared to be a demonstration that ensured the youth against emancipation. These young people seemed to remain oriented in a preadolescent way to gang standards, diffusing their identity in groups—even exaggerating the gang symbols, as though to say, "Think of me as a teen-ager, not as a person."

In initial conferences these youngsters were fairly verbal and expressed to the staff their complaints and their understanding of the history of their difficulties. They did this without compromising their loyalty to and identification with their particular deviant group standards.

They did not, for example, pretend to understand the problems of others in the household, but confined themselves initially to arguing for what they claimed to be their "rights." Nor did they encourage the therapist who tried to side with them against adult

standards. Indeed, this made them anxious and reactivated the same mechanism of contempt by which they had made distance between themselves and their fathers.

Relation to Peers

The rebels previously had participated actively with their peers and to a large extent made sense to them, but when they became the manifest patients in their families there was excessive reliance on their bonds and identification with the gang [9], at a time when their more mature age-mates had already started to shape their individual identities. They were interested in wearing symbols such as the special hairdo or black leather jacket which, with a high degree of visibility, indicated that their actions were to be regarded as an aspect of conformity to a group. Most of them in more recent years had lost some status in the gang by getting the group into trouble. For example, they might put more effort into fighting for the right to keep unusual hours than into working out with a girl friend or chum ways in which they might visit together more. Often this was done in the name of the group. One boy told his mother, "If you don't let me go and Sam or one of the others gets my girl, I'll leave home."

In this way adolescents tend to mislead the adults into fears that the objective of their rebellious demands is sexual license rather than status with the gang. While they may indulge in sexual activity, that also is usually in the service of acting out to avoid the relaxed situation where two people might get to know each other.

There is nothing subdued about these youngsters. Their fear of intimacy is such that when they date, they emit loud signals that suggest the fun is "more in the telling than in the kissing." This may indicate that their interest in recognition by gang members of the same sex is greater than the heterosexual interest, or that the interest lay in the quarrel with authority that preceded and followed the date.

Aptitude

These adolescents got in trouble with the school and the community. Their school placement was generally in accord with their mental ability despite their façade of indolence and frequent difficulties with authority. On psychological tests they showed ability to "stay with" (refrain from acting out) more anxiety than the childish adolescents.

They also showed more confidence in their own ability to do things than did youths of the other types. Figure drawings were well executed and indicated a more highly developed self-image. Role conflict was projected in test material but was less primitive. It appeared to have more to do with fear of responsibility for having an identity than with role confusion. While abstract thinking was somewhat more hampered by anxiety, resourcefulness was greater than in the other impulsive type.

Intrafamilial Relations

Homes of rebel adolescents were usually highly organized with a decidedly institutional flavor. Relatives in the home, club and board meetings, husband's long hours, wife's job, and the providing of a program for children all seem to have taken precedence over the use of opportunity for husband and wife to enjoy each other's company.

While the parents were competitive in their relations with their peers and were active in church or community affairs, they had no projects which they shared. As a couple, they had often worked out a division of roles that unwittingly fostered the weakness of one or the other. The husband, who had not learned to manage a checking account, did not get the opportunity to learn. There was a subtle aura of blackmail rather than respect in their tacit agreement not to invade established areas of privacy. The adolescent, who in our series was the one who externalized the family problems, hence the manifest patient, also had a fairly well-developed relationship with the community of his age-mates. At

home he took refuge in isolating himself from the family by use of a rebellious attitude. The manifestation of emotional instability served to protect him from intimacy and from being held accountable.

Communication. While family members were eminently able to express themselves in public, the few matters openly discussed at home were quite superficial and appeared to be without emotional involvement. To the youngsters, everything seemed to have been agreed upon in advance. Actually, the family members learned many important matters about each other, not from each other, but from other people in the community. The youth, taking his cue from this pattern, acted out his problems in school and community, relying on school counselors and others to bring his problems to the family's attention. The nub of the problem seemed to lie in tacit consent that Father was to be protected from the realities of family problems. Main channels of communication did not include him.

A nonverbal aspect of communication was that which seemed to require the child to live out aspects that the parent of the same sex had suppressed in his living. For this type it was expressed in the overt flirtatiousness of the girls and the delinquent behavior of the boys. Adelaide Johnson [10] has described this communication as proceeding from "superego lacunae" in the parents.

The Rebels at Home. These adolescents had many doubts about their manhood or womanhood. Their doubts, while a part of the whole picture of their fear of adult responsibilities, may have been fostered by the failure of the opposite-sex parent to differentiate clearly in the expressed attitude between youth and adulthood with respect to ability to assume responsibility and confidences. Early in the interview Mrs. Cramer showed the loss of perspective in relation to her son's girl friend: "I've got lots more than she has." The anxiety associated with not being refused adult privileges was noticeably reactivated when therapists seemed to side with rather than to oppose the demands of the adolescent. It was more pronounced in the way the pompous father of a rebellious

daughter responded to his wife as though she was a petitioner on equal status with the provocative daughter.

The girls in the series seemed to have stormy relations with their fathers that were ill-disguised crushes. They seemed to work hardest on the problem of how to register importantly with Father. The mother reciprocated with some rejection toward the daughter and considerable competition with her for the husband's favor or attention. The girl often responded to such rejection by dedicating much of her efforts to mother's discomfort in a way that turned the rejection into a great deal of attention.

The parent of the same sex as the manifest patient was quite unaware of the incestuous quality of the pressure on the child. The adolescent, made anxious by the lack of guarantees of differential treatment between the two generations, seemed forced into behavior that would repel the parent. Thus, rebellion both quelled overwhelming fantasies and helped present the youth as not qualified for even reasonable adolescent responsibilities. An arrest in development was manifested. The youths dealt with their doubts about themselves somewhat as their parents did. They developed a publicly recognized skill designed to demonstrate to the world their adequacy and personal worth, although privately they were unable to convince themselves of their worth. Thus, Rocky was president of his class for successive terms, just as his father said he ran for school board re-election "to prove himself."

Fathers. The majority of the fathers of these adolescents appeared to abound in "goodness," really an annoyingly unassailable attitude. At intake they were quite matter-of-fact, cooperative, and scarcely aware of their own involvement in the problems. Indeed, they seemed to have hurt feelings over recent discovery of how little they were appreciated. Their role in the home in each case seemed to grow out of spoken or unspoken agreement that Father was somehow superior. (Either he came from a family of better social standing, had a prestigious occupation, or at least had less taint than his wife felt from her past.) They were often pompous, having been put on pedestals by their very executive wives, and in

this splendid isolation they were protected from direct handling of crises. Officially they were leaders, and outside the home they were aggressive. At home, however, they functioned more in passive-aggressive fashion as critics. They had been present during the infancy and childhood of the manifest patient in half the cases. Fathers were perplexed by the loss of closeness with their daughters which had characterized their relationship until the onset of puberty.

Mothers. The mothers in this group were really capable women, almost all of whom had career training and had pitched in as wage earners during some of the years of the marriage. They were themselves quite needy, and seemed to have a particular problem about being able to give emotionally to the needs of their children. They appeared resistive and guilty at intake because they felt that investigation would reveal that they were at the root of all family difficulties. They all seemed to have made their husbands' career their own project toward social acceptability. Eight of the twenty mothers brought children into the marriage from previous marital failures. Biologically based feelings of inferiority troubled five mothers who were convalescent from long illness or unable to bear children during the early years of the marriage. Inferior social status and reputation soiled by adolescent indiscretions were felt by the remaining four as reasons for entering marriage in a poor bargaining position. Manifestation of this inferiority within the family, together with the spotlighting of the husband, may explain in part the rebellious girls' lack of identification with their mothers and the provocative attitude toward their fathers. While beholden to their husbands as though thankful for being taken in, the women picked men who had in younger years been excessively passive and obedient to their mothers. In the community these women fulfilled their committee assignments with competence but not aggressively. They accepted work as a part of the obligation incurred in connection with sponsoring their husbands' success. Thus, their role was aggressive at home but more passive-aggressive in the community—a reciprocal relationship to that of their husbands.

Sibling Situation. At the time of the crises, the manifest patient was either the oldest or the only child in the home, although in a few cases an older brother had recently left home. While there were relatively few complaints in the area of sibling rivalry, the patients seemed to resent the freedom of younger siblings. Where competition existed, it was for the privileges of the youngest for irresponsibility, which was an aspect of passive dependency rather than rebellion. The adolescent, however, did not resign his seniority rights as did the more childish type described later in this chapter. The younger sibling actually seemed to have looked up to the nominal patient with some admiration but also with a fear that he could never deal with his parents on such equal footing, a misperception that may have accounted for the prolonged passive dependency of the younger children in these families.

Family Constellation. A description of the immature aspect of the family functioning has to do with the interaction of a youth who manifests emotional instability in a rebellious way; with a father who is aggressive outside the family and passive-aggressive at home; with a mother who is aggressive at home but passive-aggressive outside; and with a passive-dependent younger sibling (Fig. 4-1). The greater role flexibility of the parents may be reflected not only by the ability of the family to bring its youth through the earlier developmental stages to the beginning of heterosexual adjustment, but also by confidence, greater than the other types of youth showed, in their own ability to do things.

FIG. 4-1. Family Constellation for Preadolescent Functioning in Adolescence.

* Parentheses indicate role outside the home.



As with Rocky Cramer, the pathological condition was at times augmented by the unsuitability of the youth's personality for the role induced by the situation. The suitability of a personality for the position is an additional variable to be considered in assessing the mental health hazard of any position outside the central circle in Figs. 4-1, 4-2, 4-3, and 4-4.

Crisis

Temporary hospitalization and training school placement had been tried in many of the cases. Typically, at the crisis there was a mobilization of the family to try to keep an immature youngster in the family despite behavior indicating a rejecting of the family. These families came to the hospital center for recommendation of some definitive kind of action, but not to separate the child from the home.

In contrast with guilt-free acting out of the childish adolescents who, like Peter Jones, appeared to be struggling for a sham autonomy, this group seemed to have a real fear of achieving individual identity.

THE INTIMIDATED YOUTH AND HIS FAMILY

An arrest of development at a psychosocial level between that of the autocrats like Peter Jones and the rebels like Rocky Cramer is hypothesized for the anxious and fearful group of neurotic youngsters whom we have designated as *intimidated youth*, or *juvenile functioning* in adolescence. The following study of the Critchlows illustrates this type of youngster and his family relationships.

Bronco Critchlow, a 13-year-old boy, was referred by the principal through the school nurse because of annoying behavior that disrupted the class and seemed to contribute to the lad's school failure. It was a very tense and anxious boy who appeared at the clinic with his family. He was of usual size for his age, but slightly overweight. His habit of pulling out his hair was betrayed by a large, asymmetrical bald spot surrounded by tufty stubble, grown since his father had shaved his head a week before. His marked overbite with protruding teeth, together with a receding lower jaw, contributed to his forlorn appearance.

His very appearance seemed to irritate his father, a stalwart, well-built man; the slight graying of his hair indicated his 36 years despite a youthful, almost boyish manner. Initially, it was the father who presented the complaints. He told of the many punitive measures he had used to stop his son from pulling his hair, sucking his thumb, and being afraid. He reported some descriptions he had given his son of how he himself had experienced fear under enemy fire and other really dangerous situations. All of these seemed to lead to a crescendo of contempt for his son's unabashed cowardice. Another theme pointed to his son's seemingly pathetic ineptitude. Father had, with patience, but in excessive detail, told him exactly how to mow the lawn. The boy, then 11 years old, always seemed to have the mower expel grass on the sidewalk or on the neighbor's side of the property line. With some richness of humor, Mrs. Critchlow would interrupt and finish these descriptions in a way that seemed to play down the magnitude of the complaint and to show that her husband responded with frenzied anger and abuse of the child. Mr. Critchlow, then, on each occasion, fitted the misdemeanors into a series which could be projected toward a disastrous outcome. The boy had stolen a trinket at the age of 3, items of little value from a store at the age of 8, and recently \$20 from a well-to-do relative. Did this not prove criminal tendencies? It seemed obvious that Mr. Critchlow was most afraid of fear itself and that his son could provoke this fear easily.

Mrs. Critchlow was a grotesquely obese woman with attractive dark hair, a clear complexion, and good features. She seemed to respond to most situations with a wealth of well-told anecdotes. Particularly with the male therapists she could show a side of herself that was culturally rich. She was prone to present reminiscence of her earlier life in a border town among the friends of her mother, a retired actress, and a father who outwardly indulged his wife with gallantry but suffered in silence. Close examination revealed that her narcissistic mother was neglectful and her father was remote. As the youngest daughter, Mrs. Critchlow had concentrated in her youth on being dutiful to parents, while her own social life was but a fringe benefit reflected from that of her more aggressive older sisters. In answer to a question as to what preceded her overeating, she said she sought escape first in excesses of entertainment; that is, when not attending to her parents she was lonely and sought distraction. Then, at about the age of 14, when family pressure to keep up appearance was exerted, she turned to overeating, a pattern to which she returned after the birth of her first child.

Another striking feature of Mrs. Critchlow's adjustment was her

many fears for herself and her children. She felt it unsafe to leave the children, aged 10, 12, and 15, alone at home even for brief periods during the day for fear of strangers breaking into the home and harming them. She opposed most vigorous activities of children because of the possibility of harm. In general, the message to them was that the outside world was dangerous. The first years of her marriage were reported as a miserable life under fear of her husband's temper and the tyranny of his self-imposed standards of achievement and conformity. Little realizing that her own fearfulness was part of the stimulus to his excessively aggressive façade, she dedicated herself to protecting the children from his anger. In these first years they lived in several parts of the country, but nowhere could the mother allow herself any friendly contacts outside the home. She felt disapproved by her husband and hopelessly cut off from the only community where she had importance. She reported that she felt so much love for her first child that she thought her love would hurt the child, and therefore she corrected this by eating a great deal. When the family came for MIT she weighed 270 pounds, having gained 40 pounds within six months after the birth of each child, and never having lost any of the added weight. In this way, the more easily expressed reason for being afraid to socialize appeared. She knew her appearance was repulsive.

The use of fear, inadequacy, and repelling appearance to explain a lack of friends was readily adopted by Bronco, the middle child. By virtue of being the focus of his parents' anxious concern, he seemed to have permitted his older and younger sisters a less troublesome course of development.

Bessie, age 15, pretty, plump, and blonde, seemed quite composed, somewhat cool, and less anxious at the initial visit to the clinic than the other members of her family. Her composure, however, belied underlying anxiety indicated by the way she peeled off her nail polish and picked at her fingernails. She also reacted with some anxiety to her father's attitude toward her when he apparently failed to recognize the difference between their respective generations. It was surprising to see the display of hurt feelings on her father's part when, in that initial family interview, she happened to describe an age-mate of her father as an "older man." He questioned her sharply about this, and a team member called attention to Mr. Critchlow's difficulty in accepting the fact that he was not perceived as youthful by young people. (While the family constellation from Bessie's standpoint had characteristics of those of the rebel, that problem was not sufficient to yield a serious arrest in Bessie's development.)

Mr. Critchlow's problem with accepting his own maturity also interfered with his occupational adjustment, and contributed to the excesses of aggressive façade. The positions he held were those open only to younger men. As an aircraft equipment inspector for the government, he felt it important to continue to keep up his flying skills even though he had several costly accidents. He was continually in training to compete with the younger technicians, preparing for positions for which he would soon be overage. His was not a pursuit of knowledge so much as an adjustment to the perpetual student status.

Mr. Critchlow really expected to be granted both the privilege of childish instability and the recognition of his masculinity. At work on his government job, he accepted and defended all the supervisory regulations as just, immutable, and paternal. He prided himself on his conformity and showed corresponding shock when his wife and son did not seem so concerned with gaining approval. Indeed, Mr. Critchlow told his employer to check him if he overstepped his bounds because of temper. When he did, in fact, win criticism for impulsive behavior, he spoke in rage to his supervisors that they had not kept their part of his "bargain" in that they had not advised him of the need for self-restraint soon enough.

At home he made the same charge of his wife. She was to be responsible for advising him to control his temper. She was also supposed to force their son to plan his activities and to fight back when bullied. In these ways he demanded mothering for himself, though sometimes he asked for it as though he wanted it for the children. The father's demands made him, in effect, a rival of the children for his wife's ministrations. His competitive advantage here was that his wife freely admitted being a handicapped person while he denied his obvious dependency.

Mrs. Critchlow, in turn, expected her husband to restrain her from overeating. She ridiculed the fantastic extremes to which her husband wished his programs for the control of the children to be carried out, but she gave his orders some limited compliance while complaining bitterly of the way she was neglected. Her overprotective attitude toward the children expressed both her fears of the world and her compliance with her husband who fostered her homebound ways as well as her rivalry with the children for paternal care from her husband.

Appropriately, the boy's ventures away from the house were loaded with symptoms. Though his parents did not allow him to go far, Bronco failed to explore even the area beyond his block. He seemed to panic when lost, caught between expressing Mother's fear of the world and

supporting Father's doubts about the possibility of his son's gaining acceptance into the world of men.

Unable to win recognition from Father, he turned to other frightened leaders, but within the same pattern. He propitiated the bullies. His rides on the school bus became a series of nightmarish experiences. If he had a seat, the bullies made him stand anyway; they burned him with cigarettes and ridiculed his appearance. By applying what had been observed of Bronco's use of symptoms in dealing with his family, the team and family were able to see this as consistent success at fascinating the bullies. While it substituted for popularity, it also justified his nonparticipation in the many activities by which children assess each other's capabilities. Like his father, he did not really feel equality with peers. In a way that showed his readiness to identify with whatever aspect of Father could be at all clearly discerned, Bronco, too, became interested in regulations; particularly those with an equalitarian goal. This reflected Father's adherence to, and interest in, civil service rules. Bronco asserted that whatever one gets another should get. Most recently he had questioned that more should be spent on his father's fishing pole than on his own. This kind of rule offered, of course, relief from competition which he feared. It also offered a rationalization for stealing to make up his lack of equality. The trinkets he stole were used to buy "friends."

Thus, divided many ways in his efforts to please, to fascinate at any cost, to repel, and to avoid appraisal, Bronco became inefficient in school and an object of concern to teachers and parents. The boy's symptoms began to expose the intrafamilial problems. Father's leadership was again under fire.

When asked to recall his own youth, Mr. Critchlow protested that he himself was much more like his mother than his father. He felt that his father was rather remote, and that he knew more of how a mother would handle children. His father was good at mathematics whereas he, like his mother, had a great distaste for them. His mother, however, was lenient concerning his own escapades, which had included stealing and vandalism. Unable to cast a masculine image to his own satisfaction, he retreated behind pat formulas. He felt that his son should consult him about problems, but on each issue that might arise he was able to quote himself at length on his stand. It seemed obvious that it was pointless for Bronco to bring problems to his father because he was expected to know in advance his father's intolerant attitude. Bronco was supposed to feel free to bring his financial needs to his dad, who always made clear that the family's financial circumstances were im-

possible. He was supposed to bring his fears to his father, who always told him it was disgraceful to be afraid. Actually, Bronco could only negotiate through his symptoms and occasionally through having his sister approach his father for him.

Discussions at home between the parents always became unproductive arguments. Neither parent granted the other intellectual or educational superiority. Competition between them for recognition by each other was keen. This may have contributed to Mr. Critchlow's continual student status. Both also sought parental acceptance from Mrs. Critchlow's parents, from the family doctor, and from the many experts such as ourselves who were brought in to referee. Typically, Mrs. Critchlow's device was to cast doubt on the strength of her husband's position. He usually responded in panic by extending his position to the point of defending an absurdity with only the threat to use force on his side. This was usually manifested by impotent rage. The reaction on the children was one of intimidation. To be grown up in this family appeared to them to require the ability to do battle with Father. Bronco despaired of reaching manhood, since the fears with which he was beset were the ones criticized by Father as an aspect of womanhood. Somehow he always felt included when Mother was criticized.

Such competitive family relations characterized the families of the 14 anxious and fearful youths who were considered to manifest juvenile functioning in adolescence and preadolescence. A feature of this group of 11 boys and 3 girls that led to its study was that of the more narrow age range of the manifest patients. The fact that they became child guidance problems between 11 and 13 years of age, and that they were not referred for rebelliousness, suggested investigation of whether some types of families may have special difficulties in bringing their youth through this growth stage.

These 14 youngsters were referred for a variety of neurotic traits, repelling habits, and somatic symptoms such as headaches and gastrointestinal disturbances which had led to actual or imminent exclusion from school.

While this project was designed for therapy primarily with adolescents and their families, three younger children aged 6, 7,

and 8 were referred from pediatric sources and were included in this study. All three were representative of the intimidated youth. Since many small children referred to child guidance clinics present similar symptoms, it may be that our sample of 14 youngsters of this type are but a part of the whole picture of childhood neuroses.

Relation to Authority

These children seemed to be intimidated by authority. When they participated in antisocial acts, it was usually for the purpose of winning the approval or protection of someone in a position of strength. Thus, a few came in contact with legal authorities because they had served a gang leader or a bully by, for example, actually climbing through the window to get the loot in a robbery from which their only benefit was imagined status for risk taking. They were used and "left holding the bag." Additional trouble with school authorities came from school phobia manifested by some. Others had persistent and repelling traits of hyperactivity, flatulence, and sloppiness. They were overserious, worried children who, by their normal intelligence and their ability to speak in the language of the adult, led their teachers to expect much from them. Anxiety or fear of clear appraisal of their abilities resulted in unfinished or poorly finished assignments, or in procrastination. They acted toward paternal authority as though they expected and feared retaliation for the amount of Mother's concern that was directed toward them and their symptoms. They seemed to fear the responsibility that might go with evidence of competence or initiative. They betrayed their own guilt in a way suggesting that their failures and petty larcenies were supposed to let others in on their helplessness against authority.

Relation to Peers

These youngsters were eager to be accepted by their peers and would take considerable risks to be regarded as "one of the gang." But they were not able to communicate with peers. Their adult-value-centeredness set them apart from the antiadult group norms of preadolescence. Their pervasive feelings of inferiority required

that they should not let themselves be really appraised by their age-mates. Because older youths did not expect equal performance of them, and because they had a natural advantage with younger children, they often tried to associate with older and younger groups. Their lack of real belonging to groups was abetted by their poor performance in competitive activities. Intimidated by peers and adults alike, they were peripheral observers to competitive activities. The kind of naïve understanding they had of what either adults or peers communicated is illustrated by Pat Oxley and his dung bomb.

Pat was arrested and charged with arson for setting a fire on a school-teacher's porch. He had wrapped dung in newspaper, set it afire on the porch, rung the doorbell, and retired to watch the teacher step on it. Details of the incident revealed that he himself had nothing against the teacher and barely knew him. His father, however, had expressed considerable contempt for the man as a scoutmaster. A few weeks before, the teacher himself had described such a prank to his class as an amusing reminiscence of his own childhood. Pat Oxley had heard a group of older boys from that class describe the trick as though they would like to try it. Here was a ready-made opportunity to win approval from a group he admired and to feel some identification with his father. It actually took hard work on the part of a team of therapists to show this as anything other than rebellious meanness.

That the efforts of these youngsters seemed always to lead to rejection only added to their anxiety because of the embarrassing fact that they were "only trying to please."

As might be expected in latency, there were no special problems with youth of the opposite sex. Some boys associated mostly with girl playmates because they felt rejected by the boys. Others seemed to be more aware of the stigma many small boys attach to association with girls and remained lonely. All were somewhat deficient in peer-group associations regardless of sex.

Aptitude

Despite their low marks on school reports, these children's scores on national achievement tests were appropriate to their age and grade placement. Their anxious uncertainty hampered their

school adjustment, as indicated by assignments turned in late, and acute self-consciousness or stage fright when called on to recite in class. Some, like Bronco Critchlow, were almost immobilized by anxiety when faced with tests or examinations. Their somatic complaints resulted in frequent absences from school and three had developed classic "school phobia."

In general, the intimidated youth showed a distressing amount of hyperactivity and inefficiency in school, which usually led the teachers to feel "they could do better." On psychological tests, these overserious youngsters showed effects of having internalized more of the adult-sanctioned standards than did the more impulsive youths of the other types. This was shown in relatively better scores in tests of the fund of knowledge and of speed and accuracy. Their verbal scores on the Wechsler-Bellevue scale were higher than performance test scores. They were awkward socially as well as in ordinary manual tasks. Rorschach's test showed them to be relatively unimaginative, and the picture arrangements test reflected their poor insight into social situations. However, as indicated above, in spite of their apparent inefficiency they were able to learn at a level appropriate to their mental ability.

Intrafamilial Relations

Competitive relationships had well-nigh displaced tenderness from the homes of intimidated youth. The parents were strongly competitive for authority, each claiming that he or she had the right idea about the proper rearing of children. Sibling rivalry was intense. Wives were competitive with the children for husbands' favor; and fathers, while seeming to instruct their wives in child rearing, were really asking for mothering for themselves. The parents quarreled frequently and openly in the children's presence about inconsequential details or about child rearing.

Prior to marriage, the mothers of these children had some degree of satisfying community relationships, either socially or in job experiences. Marriage and child rearing were regarded by them as unhappy interruptions of what they recalled as carefree youth.

Some of them complained that the demands their husbands made of them, particularly for the attentive care and supervision of the children, excluded the possibility of activities outside the home. None of these couples had satisfying social or recreational activities, either separately or together; however, 5 of the 14 mothers were employed outside the home.

The fathers in our series generally led socially narrow lives. Most of them had a reputation for being hard to get along with and showed limited adaptability in their vocational life. The nominal patient had often internalized the father's patterns of conformity and overconscientiousness.

The families of the intimidated youth were characterized by having both parents of approximately equal strength and influence, but at the manifest level not cooperating with each other. At the covert level there was collusion to prevent intimacy or tenderness, both of which were presumed by the parents to lead to exposure of unmanliness in the male and unwomanliness in the female. The covert threat was often brought to the surface during therapy in the form, "If you try to show I'm no man, I'll show you're no woman." Indeed, many of these men, when they helped or advised on housekeeping matters, seemed trying to outwoman their wives. In most cases, the marriage was at a critical point. Where arguments had previously led to a truce which said, "We stay together only for the children," now the school difficulties of the children served to cast doubt on the worth of such a truce.

Where other types of families maintained longer the initial attitude, "We only consult you about the children," these families from the start were more eager to discuss marital problems. Initial cooperativeness was high; however, it quickly resolved into a persistent appeal for dependency in the manner of help-rejecting complainers [11]. They tended to preserve the child's symptoms as something to point toward to support the claim that the team was not giving them enough help.

Communication. Excesses of verbal barrages characterized intrafamilial discussion in the families of intimidated youth. The

informational content was slight and predictable. Typically, the mother was loquacious and she was prone to criticize her husband's ability as a provider, either directly or by innuendo. The husband typically responded with anger, impotent assertions, and ultimatums. Each parent accused the other of lack of understanding or consideration for the spouse's feelings. The hostile dependency of each on the other was implicit in these requests for "consideration," i.e., parental care. Talking in general seemed to be a denial process by which one concealed feelings.

The children seemed able to talk to their teachers in a surprisingly adult way although at home they tended to be inhibited in verbal communication. Their only effective communication with parents was through their symptoms, which demanded care and attention.

The values transmitted from parents to children were concerned with scarcity, fear of deprivation, and fear of self-revelation. Identification of the child with the parent of same sex was fairly well developed in these youngsters, in contrast to the more childish youth described in the next section. The parents, however, gave an unclear image to be used as a model for identification, because each parent seemed to specialize in knowledge of the role of the other parent. The fathers, particularly, repelled closeness by their stern attitude and their lack of recreation, fun, or joy in living. The example they set provided their sons with very little incentive to grow up and become men.

The Intimidated Youth in the Home. These youngsters suffered mightily from the disapproval of the parent of the same sex. But they brought a lot of it on themselves. By their anxious, clumsy, fearful behavior, they excited the parents' intolerance for weakness in others. This symptom seemed to have as its purpose discouraging the parent from expecting too much. The boys seemed to sense the necessity of staying inept to guarantee that they represented no real competition to their fathers. Startle reactions and cringing when a father spoke sharply were not unusual. School phobia in three of these children seemed not so much a fear of

school as a fear of losing a position of importance at home. An arrest in development was manifested at the juvenile stage where youngsters no longer treat each other as inanimate things, but indeed are studying competition and compromise and are participant with age-mates. The children in this group stopped short of being able to be intimate with their peers of the same sex. This outsider role was a source of embarrassment to conforming parents who wanted their children to progress socially as well as educationally by the very public public-school standards.

Fathers. The fathers were frightened men. They became tyrants in their own homes largely from their compulsion to deny dependency, uncertainty, or anything that might cast doubt on their masculine adequacy. Their standard of manhood was distorted in an excessively aggressive direction. Thus, the fathers behaved as though they had delegated to their wives only limited authority with the children. The wives, who had similar self-doubts and aggressive tendencies, responded to the aggressive attempts to dominate by passive-aggressive techniques which directed blame for failures and for the children's difficulties toward the fathers' leadership.

Seven of the fathers were present in the home during all of the early life of the nominal patients. This is in contrast to the rebels and the autocrats, in whose infancy many of the fathers were away in military service. Five of these intimidated youth were the natural children of the mother only, having been born of earlier unstable marriages during the war years. The new fathers seemed to think that their wives' earlier marriage failures disqualified them as adequate mothers, and that they, the fathers, must therefore assume a corrective task. The tendency to undertake the direction of others contributed to the devastating feelings they suffered because of their strong desire to depend on the people they attempted to direct. Their relations with their children were rarely so direct as to vie openly for the maternal role. Relationship with the children often had the aspect of having been delegated to the mother with instructions. What such a father asked

for the children sounded very much like what he wanted for himself. However, his need to deny dependency prevented him from perceiving himself as a rival with the child for his wife's "mothering" attention.

Mothers. These women openly resented the insult to their womanhood implied by husbands who coach them in mothering. Three seemed to have settled for acting like an older sister to the children. Three others acted more like hired maids and carried out their husbands' instructions in order to win approval when things went well, but they reserved the right to blame a husband when things went wrong. Two others who seemed very needy of masculine approval tended to reject the children and seek male acceptance elsewhere than in the home. Another two overindulged their children, much to the frustration of the needy husbands.

The mothers had inadequacies very similar to those of their husbands. They had selected mates with dependency needs similar to their own, mistaking similarity for understanding. Both expressed denial of dependency through aggressive attitudes. The expression of aggression yielded more conflict in the women because the constellation cast them in a passive-aggressive role. Conflict in their husbands was also intense because of unsuitability for the leadership role toward which aggression impelled them. The mothers too were afraid of weakness and felt ill protected by the unstable attitudes of their husbands. They tended to respond to these difficulties with contempt. Their habitual way of relating to authority was to propitiate, to try to please. They blamed their husbands for their meager social life, but in fact doubts about their own social adequacy were equally important. On the whole, these women were more inclined than were those of the other types to regard themselves as desirable to men. The effort for gratification of their own narcissistic needs added to the children's feeling of rejection.

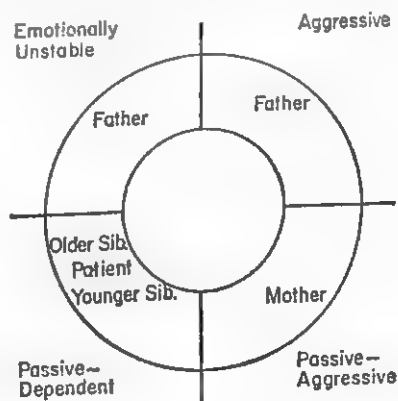
In this situation of scarcity, a division of roles naturally appeared among the children whereby one of them—the nominal patient—tended to exploit the mother's unmet needs by having

symptoms which demanded care. These symptoms seemed to have a goal for the child of appealing to both parents as though to deny the rivalry with the parent of the opposite sex. The symptoms also won him exceptions from the excessive expectations of the parents and from competitive status with peers. Other children in the family won the attention of their parents through "goodness," conformity, or outright passive dependency.

Sibling Situation. Although these youngsters were not vigorous competitors in peer-group situations, at home sibling rivalry was intense. Frequently the goal of argumentative behavior at home was to avoid being held responsible. This may have resulted from the youngsters' having witnessed frequently arguments between the parents in which the claim to capability and competence was rewarded only with blame. The attitude of the "middle child" who failed to win attention by initiative or dependency was typical among the intimidated youth.

Family Constellation. A diagram of the immature aspect of the family's functioning (Fig. 4-2) shows the intimidated nominal patient and his siblings in the passive-dependent position with the "well sibling" [12] ranged above him in the aggressive direction, and the younger sibling below him on a continuum toward passivity. The father in this type of family tends toward the extreme of the aggressive position, but he also reserves the right to occupy the impulsive position. That is, when he is overextended by his

FIG. 4-2. Family Constellation for Juvenile Functioning in Adolescence.



assertions it is expected in the family that he will have the tantrum and a display of emotional instability. The mothers function with respect to the rest of the family from the passive-aggressive position. A mental health issue is suggested by the fact that they may be personally ill suited to this position by reason of their aggressiveness and lack of opportunity for release in instability allowed the fathers. These unmet needs for expression may account for the intensity of hostility with which they force their husbands toward extremes of pretense and of instability, and for their tendency to foster symptoms of illness in a child as a condition for special attention.

Crisis

The child's symptoms in each case brought family tension in the home to an intolerable pitch. The parents were actually uncomfortable about the child's problems and about their own marital discord. The events leading to referral and request for help at this clinic included in most cases the parents' public embarrassment because of the child's failure by community and parental standards. For example, the parents felt embarrassment and shame when their child dropped out of school or failed a grade, or exhibited bald spots on his head as Bronco did. Blame-placing efforts by the parents only increased the child's symptoms. The parents came seeking both relief of the child's symptoms and help with the mutual intolerance that had shaded their marriage.

In such a situation of chaotic leadership the youngster could only be sure that a real handicap was rewarded. Unable to rebel or have things their own way, the youngsters relied on symptoms to speak for them. By symptoms rather than by antisocial acts they externalized the family difficulty. The parents' dependency problems and their discomfort with themselves and each other made them more willing than some other couples to work with us on a study of their own limitations as well as their children's problems. In contrast to both the unsocialized aggressive behavior of the youth like Peter Jones and the rebellious behavior of those

like Rocky Cramer, these youngsters were subdued, afraid to move ahead, afraid to take initiative, yet their developing consciences would not allow them to go back to childish ways.

THE AUTOCRAT AND HIS FAMILY

The relationship within families which presented the arrogant *childish functioning in adolescence* is illustrated by Peter Jones and his family, described in Chap. 2. This type, the *autocrat*, was represented by 20 boys and one girl in our study. The usual age at referral for this group was 15 years, very close to the age of the rebels, who were usually referred at age 16. This is in contrast to the intimidated youth, who were referred as patients at a younger age.

The autocrats were referred because of aggressive behavior that appeared to be uncontrollable. The complaints included temper tantrums, physical assault with threats to the life of the parents, destruction of property at home and at school, truancy, car theft, running away, and failing at most adult-sponsored projects. Conventional diagnoses located their difficulties among the character and behavior disorders including near-psychotic, schizoid, and psychopathic personalities. They were particularly unable to tolerate experiences which cast doubt on their ability to have their way. By negativism, by violent assertions, and by avoiding clear tests of their limitations, they defended themselves against any recognition of limits to their power. They did not retreat from reality into delusion or autistic living as did the more schizophrenic type, but they too sought to preserve some of that omnipotence carried from infancy into early childhood.

The following background information from the case reported in Chap. 2 is material reported by the probation officer when he first took Peter Jones, then 14, into custody.

Mrs. Jones told the probation officer that she had lived in fear for her life for the past two years. Six months ago Peter had threatened her with a crowbar when she refused to relinquish the car keys. To the family's knowledge, the boy's only driving experience was with a motor

scooter. Mrs. Jones attempted to call the police, but in her excitement she was unable to dial the number correctly. Nevertheless, a few minutes later Peter was arrested for speeding. A year before, when his father told him not to drive the motor scooter for a day, Peter swore at him. Father jerked him off the scooter and shook him. Peter told others of his intent to kill his father. The next time the father denied his request to visit a friend, Peter took a knife and asked his father to fight so he could cut him. The boy explained to the probation officer that he got along all right with his mother except when she did not give him what he wanted, that there was nothing really wrong with his parents.

Relation to Authority

In contrast to the rebellious group, these youths had little or no interest in constituted authority. They simply could not recognize authority. This failure, of course, regularly brought them into conflict with authority, including teachers and police, to which conflict they responded in primitive ways. But authority figures outside the home were not the real object of their insubordination and were only exposed to its force when their efforts resembled those of parents. The blindness to authority seemed to have been developed with the parents. The threshold for tolerance of frustration in these adolescents was extremely low, and they responded to even mild authoritative direction or correction with fury. The authority figures involved usually sensed something sick or inappropriate about the autocratic youth's way of relating to them. It was not rebellion, not a struggle for freedom, not a bid for attention, but simply an inability to tolerate limits.

Relation to Peers

Having specialized too long in the manipulation of adults in the home, these adolescents were out of contact with age-mates. They tended to treat other people, youngsters and adults, as things rather than persons, just as infants and very young children do. When they played with others, play had to be on the autocrats' terms or not at all. This frequently reduced them to playing only with younger children who would obey them or with older children

who could exploit their readiness to perform acts of violence and destructiveness. In Sullivan's terms, they had not left the area of childhood which he defines as extending to "the maturation of the capacity for living with compeers" [2].

Aptitude

Unable to tolerate control by others, these children had for many years made themselves unpopular with their teachers. Since any awareness of limits to their power was intolerable to the autocrats, they found security in the formula, "You don't reject me, I make you hate me." It did not seem to be from interest in the teacher as another person that they occasionally dedicated themselves to the teacher's discomfort, but only when, like the involved parent, the teacher seemed to have a stake in goals set for the child. Compulsively the child had to make the teacher fail. Autonomy from the consuming relationship with the mothering one was the child's goal. At such times the separate identity of the teacher was poorly visualized by the child, and the teachers showed that they sensed the inappropriateness by reporting the child as sick rather than as mean.

Educationally these teen-age youths were a grade or more retarded and in fact were very poorly educated in comparison with classmates. On psychological tests they showed a poor fund of knowledge in spite of average or better learning ability. In contrast with rebels, the autocrats did relatively better on psychological tests influenced by the presence of anxiousness, such as the arithmetic subtest on the Wechsler-Bellevue. Projective testing indicated them to be relatively less imaginative and to have rather vague and ill-formed self-images. More than in other types, the anti-learning attitude appeared to be a durable aspect of the character defense.

Intrafamilial Relations

Homes of autocrats were void of any organizing spirit. They were families with gray-looking, depressed, and excluded fathers.

The mothers had lost sight of usual adult sources of satisfaction, having found a more dependable emotional outlet in the relationship with the nominal patient. The expressed interest of the mother was in getting the mother-child relationship back to smooth-running, mutually consuming symbiotic relationship that characterized the later infancy of the child. A disenchantment had come over that relationship. The mother found it necessary to seek assistance in protecting herself and in controlling the child's behavior. The child, now adolescent, sensed this as rejection by the mother, who had been his slave and his playmate, and he attempted by violence to force her to continue in this role.

Mr. Gautier first became aware of his son's physically aggressive attacks on Mrs. Gautier when she suffered two broken ribs from Ted's violent response to her attempt to force him to clean his room. She then appealed to her husband for help in controlling the lad.

In an individual session with the mother, the social worker called attention to the intake data which indicated that Ted had been hitting his mother regularly for 10 years. Her reply indicated little insight into her own provocative role. "Well, he was a little bit at times. He would be playing and then it would get a little bit rough. And I did play with him an awful lot since he didn't have his father. I felt like I should be both parents. So we did play and have regular wrestling parties—not real rough or anything. And when he started rough, well, then I said, 'Teddy, that's enough.' Then when he got a little older, when he got to be 7 or 8 years old, he would grab me in the back of the leg and bite me. But I would paddle him for those things and he wouldn't stop it, you know. But really fighting me, just as a man would, has been just about a year and a half."

There were two exceptions in our series, Helson and Veats, where the roles of mother and father were quite reversed in most of the attributes and interpersonal patterns here described.

Communication. The fathers were more observers than participants in the family, and therefore they often had at hand data useful for the repair of family difficulties. Their comments and recommendations were usually ignored by the wives and children

because there was agreement among the rest of the family that Father's opinion did not count; they were disqualified and not heard. The "double-bind" style of communication described by Bateson and Weakland [13] was characteristic of the mothers, although it was less obscure, oblique, and insidious than in more schizophrenic families.

Power, the striving to gain it and keep it, is the key to understanding the autocrat. This youngster does not seek tenderness. He wants only the power to command.

While he carefully protects a fantasy that he may be all-powerful, he does not put it to test, nor does he risk any test of personal worth. Thus, his way of negotiating with others is one of pressing claims. He does not ask to be given anything; he only claims what is his own, and he usually begins by mentioning the basis of his claim. Here the process described by Edmund Bergler [14], "grievance collecting," may provide the currency. "Father hit me yesterday, so I need tolerate no opposition to my demand today," was typical of Peter Jones's way.

The vigilance required in these negotiations may be a factor in the suppression of tenderness, which is equated with weakness. This vigilance may also help prevent an escape into psychosis, although 3 of these 21 youths did become psychotic when the mutually exploitative relationship with the parent deteriorated.

In terms of value transmission—and here again our model comes from Adelaide Johnson's article on "superego lacunae" [10]—the nominal patient seems to be living out the mother's expressed but unrealized desire to do just as she pleases. Genetically considered, the transmission from father to son is less by the identification processes seen in adolescents functioning at the juvenile and pre-adolescent level, and more by the imitative process typical of earlier life. The young people make a caricature of their fathers' constructive interests. For example, a diesel mechanic's son was engrossed in the destructive modification of cars (hot rods), and a construction engineer's son was fascinated by explosives (de-

struction). The imitation in caricature may be a frustration response to the "damned if you do, damned if you don't," effect of communication with the mother.

The Autocrats in the Home. These youngsters are not much concerned about the public image of their manhood or womanhood. The need for an audience response in this stage is said by Sullivan [15] to have more to do with the development of techniques for manipulating people, and it does not contribute to the sense of adequacy.

The autocrats who were referred to us had been engaged in a struggle for an autonomy that their parents seemed emotionally unable to grant. The negativism of the 2-year-old, which signals the need for recognition of individuality, persisted unrecognized by an uncooperative parent who emotionally could not complete the delivery of the child into the world. On his side, the child was exploiting the power derived from the dedication of the parent to himself. Having little experience with the kind of mutual respect that builds trust in self and others, he trusted only what he could command. He had little reason to doubt his control of the overinvolved parent. The heavy reliance on the threat to influence by absence, including suicide threats—"You'll be sorry when I'm gone"—gives a clue to the dynamics. When ineffective, such threats were a prelude to depression.

Boyd Kinser did not stay with the rehabilitating family unit of his stepfather after MIT, but went to live first with his natural father, then with his married sister. Thus he avoided recognition of his mother's release. She urged him to get a driver's license for his job of helper on a delivery van. Instead, he bought a car and took a trip. He soon found himself in difficulties. He lost his job because he failed to report to work, and accumulated several traffic tickets for driving without a license. When he realized he could not successfully defy his employer or the highway police, he became depressed. On two different occasions he cut and bruised himself and pretended that he had been kidnaped and tortured by thugs who wanted information about the time and place his former employer paid the men.

It appeared to be more comfortable to these arrogant youths to be firmly hated than to pass unnoticed. They trusted only power. Rather than take a chance on acceptance or rejection by others, they took command and made others discriminate against them. It was usual for them not to manifest guilt or anxiousness. These emotions, which denote some feeling of responsibility, were an aspect of themselves which still resided in the parent. "How could Peter feel guilty? Mother felt and expressed the guilt!" This was the comment of the research team doctor who arranged the MIT intake with the hospital psychiatrist. Absence of guilt had been in part the basis of the hospital's initial diagnosis of psychopathic personality.

Fathers. Most fathers of autocrats began their participation in the life of the family after this particular mother-child relationship had developed during the fathers' absence, frequently in military service. The fathers were all dealt with by the manifest patient as though they were intruders. They were, or they became, reluctant to exercise authority in the home. As a rule, they functioned in a passive-aggressive way, unwittingly permitting their wives, who needed their support, to fail in efforts to control these youths.

At intake they often behaved as though they should be regarded only as the ones who chauffeured their families to the clinic. The message to the family was, "Think of me as a provider." Indeed, only in this aspect of adulthood had they taken the opportunity to find validation of their manhood. Their wives, it appeared—and Mrs. Jones indeed said as much—selected them because they were not really capable or confident men. Among other men they were congenial and well liked, but not leaders. They tended to exclude their wives from any appreciation of their strengths outside the home. When they were questioned about this, it became readily apparent that they feared that this last stronghold would be taken over. In short, they feared their wives.

Mr. Parson was amused to learn that the team wondered why his wife had no knowledge of the financial condition of the business in

which she and the children regularly worked. He regarded us as naïve to think he might allow her such an entering wedge for control.

Inquiry into their participation in their own exclusion revealed that these fathers felt a very special relief at the birth of a child. They had felt inadequate sexually and also inadequate in the leadership aspects of social life with their wives. They welcomed the child as one who would occupy their wives' attention. Since they had somewhat sponsored this substitution with their wives, there was not really the hostile rivalry with the child which is often imputed to this relationship. Indeed, the collusion that underlay the apparent competition was as difficult for these shy people to talk about as tenderness itself. From their position of detachment, the fathers had made useful observations. Being less intensely involved, they were also more flexible. It was not difficult for them to show how the interpersonal situation of the home was really built around the inflexibility and overinvolved situation of their wives. This very condition of their wives was due in part to their own leadership default. When this interpretation was made in therapy, the fathers could accept it, perhaps because it showed them to be more important to their wives than they had suspected.

The pathological condition characteristic of these families included the child's difficulty in admitting the father's right to primacy in relationship with the mother, and the mother's difficulty in letting go of the exploitative relationship with the child. In half of the cases, these difficulties appeared to be related to the father's unwillingness or inability to disrupt the excessively close relationship between mother and child that had developed in his absence during war years.

Mothers. The mothers of the autocrats really regarded themselves as their husbands' betters. They had married "beneath" themselves and did not let their husbands forget it. The two instances of "mothering fathers" in this group followed the same pattern. Helson, in rebellion against his family, married a girl who was illegitimately pregnant, and Veats said he picked a "poor

country girl" because he could not trust the big city girls. The rest of the husbands, however, were inclined to admit to feeling tricked into marriage by scheming women.

Typically, Mrs. Linton used her church affiliation to augment her power. Her husband's influence in the family was disqualified because he did not belong to or attend church. Mrs. Jones told of how she "broke" her husband of his untidy habits because she felt that looking after him and the two children was just one too many.

These women revealed their internal conflict by the contrast between the values they expressed in words and those expressed in actions. They spoke of their intention to do just as they pleased to the point of sounding indolent. In actions they waited on their children excessively, thereby making indolence more possible for the youths. Dependency denial was usual to these women whose presenting attitudes were dominant and competitive. While a number of them had vocational training, they really lacked social skills and were not well liked in the community.

It was not at all difficult for such women to portray themselves as the power figures in the family. Indeed, at intake they gave only brief attention to blaming the husband and his ancestry, or the child's teacher and other community figures, for the child's difficulties. They were quite ready to show themselves as most powerful even if it meant showing themselves to be the root of all evil. Of course, the family should shape their lives to accommodate mother's whims!

These women, neglected by their husbands, lacking in aptitude to develop in the community any other source of adult satisfaction, were excessively at the mercy of the children. In the division of functions (or of spoils) that appeared in these homes where love was scarce (or contraband) one child sacrificed attainment of developmental goals for the fascinating short-term power to make mother happy, sad, or distressed, and in general to drain her otherwise unexpressed needs for tenderness. As puberty of this child progressed, the disparity with developmental norms became more

obvious, betraying the fault to others, and within the home the incest barrier became more ominous. The childish behavior lost its charm as the child and mother changed from a smooth symbiosis to a nagging relationship. The mother longed for freedom from this Frankenstein monster, and the child, sensing the breach in their unspoken contact, intensified his campaign.

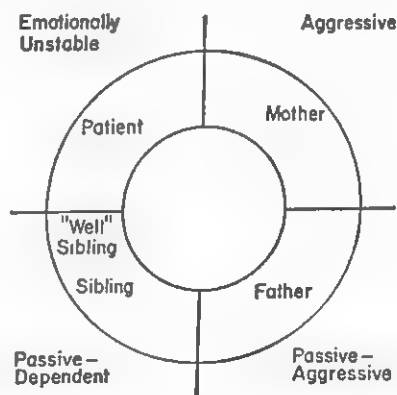
The overinvolved parent, after years of believing or acting as though child rearing was the mothering one's exclusive responsibility, often tried to give up some of that function and to delegate discipline to the spouse.

Too often, however, the mother had lost perspective on her child; her attitude toward him and expectations of him were more appropriate for a toddler than for an adolescent. When it was time for the child's adolescence, the mother was exhausted by prolonged overmothering, and in her presenting complaints at the clinic it appeared that she wanted our help to make her husband relieve her by augmenting the mothering functions.

Sibling Situation. In all but three of these families the autocrat was the oldest son in a home with younger siblings. One of the younger siblings, usually the next younger, showed considerable skill at observing and avoiding the difficulties of the manifest patient. The younger child had some of the attributes, described by J. Day [8] and others, of the "well sibling." He bid for his share of significance in the family by conformity and compliance. He might also be quite verbal in pointing out older brother's faults and instances in which he himself was unfairly treated. The championship of equal rights by the younger sibling was part of a successful invasion of the seniority of the older one. The nominal patient readily exchanged his birthright for a prolongation of the privileged relationship of childhood. The younger sibling, however, could not press his advantage and arrogate seniority rights to himself, because in his family individuality and self-reliance were not rewarded. Thus, Peter Jones's younger brother, Paul, could make clever comments about his brother that sounded like ones somebody's mother might make, but he could not learn to tie his own shoes at the age of 9.

Family Constellation. The intrafamily relationships were characterized by a father who withdrew into the passive-aggressive role of nonparticipant observer. He did little to meet the tenderness needs of his wife except to provide her with a child to exploit. He could not really control the child to whom he was thus beholden. Nor could his wife control this child on whom she was dependent for love and tenderness in her life. She could only partially validate her womanhood through maternal activity, and this really required that the children remain children. The younger siblings were intimidated into remaining in the passive-dependent relationship into which they were born. The nominal patient had no one to acknowledge as his master, and yet his mother was unable to liberate him and grant him a separate individuality. He therefore maintained his omnipotence by manipulating his mother's need for him, by embarrassing his family, and by manifesting emotional instability and unsocialized aggressive behavior. This may be graphically represented as in Fig. 4-3.

FIG. 4-3. Family Constellation for Childish Functioning in Adolescence.



Crisis

These families sought help to have the annoying behavior of the youth curbed. They did not want to alter the situation by which this child had been exploited.

Carl McLean's parents wanted the boy's stealing, lying, and vandalism stopped. But they saw no desirability in being more honest themselves. The father, a foreman, had found that many of the seem-

ingly democratic devices for exploiting labor at the plant could be used to keep his wife aggressively managing the home and doing all the labor of housekeeping and child rearing. When his son reacted to this nonleadership disguised as democracy by becoming destructive, the school and probation authorities called the behavior "sick." The family wanted this behavior suppressed.

Typically, this kind of crisis brought a heretofore excluded father more meaningfully into family relations concerning the manifest patient. The families were initially resistive. On their return after intake they often reported a change in family affairs that reflected the family's value on acting out. Peter Jones quit school and took a job. This change provided some immediate relief for which they were willing to settle rather than explore the matter further. The continued interest of the team in helping them achieve satisfaction as parents usually brought a rapid reduction in their resistance to self-study.

These teen-age youths were belatedly striving for autonomy. They were characterized by a serious deficiency in their ability to trust others, combined with some appreciation of their own ability to influence others.

THE SIX SCHIZOPHRENIC ADOLESCENTS AND THEIR FAMILIES

Infantile functioning in adolescence characterized five boys ranging in age from 14 to 17 and one 16-year-old girl. While not representative of all types of schizophrenia in adolescence, they do illustrate arrest at the most immature end of the range of developmental problems presented by the four types of families. We shall deal in a less definitive way with this type because in many respects it is a subtype to the preceding one, the autocrats, and also because the family therapy of schizophrenia has been more thoroughly studied by others [16]. We shall, however, review enough of our data to show how our work may be related to that of others.

Infantile functioning in adolescence and the family relationships are illustrated by the following study of Harold Mullins and his family.

Mrs. Mullins, a small, fairly pretty woman of 34, appeared intent and anxious in the presence of her family and seemed to try excessively to talk the professional language of the people she came to consult. Both Harold's parents had high school education and beyond that each had some vocational training. Mr. Mullins, 38, slightly obese and a bit past the prime of his once athletic build, dressed and spoke in ways that stressed his rustic background. He was an operator of petroleum processing machinery in an oil field. He was somewhat ill at ease as though his wife had brought him under duress. He had in fact resisted seeking psychiatric help for his son for the several months after the boy's first psychotic episode.

A second episode had resulted in hospitalization in Galveston by arrangement between the family physician in their North Texas community and the director of the psychiatric units of the Medical Branch hospitals. After shock treatment, the boy's hospital adjustment improved and he and his family were referred to the adolescent outpatient unit for study and recommendation.

Harold, age 17, was a somewhat obese 5-foot-7-inch lad with a high-pitched voice. His effeminate manner seemed most pronounced when he was interacting with his father, who recoiled noticeably.

Harold's first psychotic episode had been described as a "talking jag," apparently a catatonic excitement. The content of his speech at that time included large sections of material from the high school science course with moralistic overtones particularly concerned with the welfare of underprivileged people. The precipitating event appeared to be Harold's overreaction to his mother's miscarriage late in pregnancy. This was the last of five miscarriages after the birth of younger brother, Jolly. During the next few months Harold became socially insensitive and somewhat boorish in his mother's eyes, particularly in comparison with his previous ingratiating manner with her friends. A drop in his school work led to his removal to the home of relatives in a nearby village and enrollment in a different school. This was soon followed by the second episode for which he was hospitalized in Galveston. Again, the content of his speech was concern for conflicting social groups: black versus white, East versus West, North versus South, and his own promise to become politically powerful enough to rectify these problems.

Mrs. Mullins, a high school beauty queen, had married the school football hero. She was to him a city girl, and to her he appeared to show the rugged dependability of rural life. Their honeymoon cottage in the woods, it developed, was all he had in mind by way of housing.

There were promises of future inside plumbing. Alone, lonely, and pregnant, she began a pattern of complaining that her husband never brought her presents and spent too much time away. Her husband retaliated by going fishing and hunting with his buddies. Mrs. Mullins turned then to her first-born son not so much to give of herself as to gain, through use of Harold, reassurance of her femininity. Her complaint pattern then included matters more concerned with social approval. Her nagging was directed toward being seen in church on Sundays with her family. She literally drove away her husband as the child grew to provide a more immediate gratification for her otherwise unmet needs for tenderness.

The mother's emotional dependence on her eldest son for love and companionship was extreme. This lad was isolated from age-mates, a lonely and almost friendless teen-ager. Harold's expressed plans to take care of his mother when he was grown, to buy her pretty clothes, to "make up to Mother" his father's alleged neglect, suggested incestuous wishes close to consciousness. Clearly, he was "mother's boy."

His younger brother Jolly, the "well sibling" by contrast, was "father's boy." He was a competent companion in the hunting and fishing pursuits to which father often retreated from mother's disapproving harangue. Outgoing and friendly, very much "one of the gang," he was well liked and approved in high school and the community by teachers, neighbors, and peers.

Help from the team came by demonstration of Mrs. Mullins's need for her husband's appreciation of her and her need of his leadership. This started the long uphill movement. Mr. Mullins was surprised to find that the team did not regard him as a noxious influence who favored his son by staying away from him. We noticed that recognition from her husband really mattered to Mrs. Mullins, yet the stereotyped contempt she expressed toward him in his presence had precluded this possibility.

Two months after the team's initial work with the family, Harold overestimated his parents' renewed strength and reported to them his concern about several acts of homosexuality and zoophilia from the previous year. This brought the family back to the team promptly for two days of intensive work.

At Mrs. Mullins's insistence, the family had moved from an isolated rural home to a North Texas city three years before. Now, in a new effort to repair the marital discord and provide a happier home for herself and her family, Mrs. Mullins was able to take some leadership in mobilizing the family to move to a nearby rural area, where Mr. Mullins

was confident they could build a satisfactory home from the remains of an abandoned school building. She had previously expressed nothing but contempt and fear of her husband's investment in this property. When Mr. Mullins reverted to his fishing and hunting habits, and she saw herself becoming emotionally dependent on her sick son, she took a job in order to find a different kind of opportunity to validate her personal worth. She was then better able to withstand her son's psychotic reaction to her emancipation from him.

His mother's going to work and her associated decreased dependency on Harold led to another exacerbation. During a follow-up visit in the home some months later, Harold was able to describe to Dr. Schuster the feelings associated with his recent psychotic episode with remarkable insight. That this patient's way of involving the whole world in his delusions was an aspect of his problem with basic trust became clear as he described these feelings. He said that his family's efforts to suppress his difficulties seemed dishonest at the time. Feeling that parents stood between himself and his God's forgiveness, he reported having felt that he must bring his misdeeds to the attention of the whole world and then behave in an exemplary way that would vindicate himself and Christianity in the eyes of the world. At the time this was reported to Dr. Schuster, the boy had recognized the grandiosity and felt somewhat proud that he had been able to withstand this latest delusional period without acting on it. He was then making modest plans to repair his education, finish high school, and enroll in a nearby small college.

As a prelude to a more significant change when coming out of a later psychotic episode 18 months after our first work with the family, Harold declared his intention to change from "Mother's side" to "Father's side." During the subsequent month in the hospital, he worked with the MIT personnel. He reached the point of being able to formulate seriously the attitude that he felt it worth his family's while to invest in his college education without any other expectation than they share some belief in his personal worth. This was in contrast to his previous pattern of proffering great promise of international fame in political or military achievements.

During the months following his return, Harold continued his efforts to move toward his father. He learned to fish and to shoot, and he emulated his father's and brother's attitudes in somewhat forced extroversion.

This open rebellion of son against mother was complemented by the second son's moving away from father toward mother. In a way characteristic of the "well sibling's" readiness to conform and settle

for limited realization of potential, Jolly proposed substituting trade school for college training with the specific objective of getting a job near home to help his mother finance his older brother's education away from home. Competitively expressed, it would seem that he would make time with his mother now in the guise of helping his brother. However, Jolly developed other symptoms of instability as well. Rebellious like an adolescent functioning in preadolescence, he began to act out in several ways including the excessive use of alcohol, delinquent gang associations, and morbid preoccupation with his presumed lack of a future because of the presence of mental illness in the family. The rebellion served to make him the object of his mother's concern. The form of the rebellion appeared to externalize some of the unexpressed attitudes of rebellion in his father.

The mother continued to grow in interest in adult matters and, while worried, was not again captured by the attempts of her now more adolescent children to keep her occupied with their problems. When her husband could not maintain his level of participation and reverted to his previous more schizoid pattern, Mrs. Mullins divorced [17] her husband and allowed herself a new courtship. During this period her sons made more durable educational arrangements with their father's help. Harold had left military service when after a year of it he became depressed. The exacerbation of symptoms was, however, milder and readjustment appeared to be easier.

These seriously emotionally handicapped youngsters lived in an autistic fashion typical of early infancy. Physical growth changes that made them appear to be adolescent resulted in their being perceived more clearly as deviant members of their group. Pressure from school, community, relatives, and the family doctor combined to call attention to their bizarre behavior. In each case there was an annoying behavior pattern which was itself a caricature of an attribute of the "good child" of early life: Harold's recitation of his school lessons, Matt's hostile cleanliness which required that his food be untouched by human hands, the Milton boy's play-school-like absorption in drawing, and Bonnie's way of always being there in her mother's presence. All these children began to externalize too much of the quiet symbiotic relationship whereby they sold out their claim to growth for a monopoly of the mothering one. Betrayed by the child, the overinvolved parents assented to the idea

that it was madness, and then brought the child to the medical center to have him labeled psychotic, homosexual, or an outsider in the family.

Relation to Peers, Authority, and Education

Even more than did the autocrats, these youngsters treated others as things or spectators. They made little sense to their age-mates and seemed uninterested in how they impressed others. Typically, these youngsters had their authority problems with parents only. While they accomplished little in school, their teachers generally reported them as well behaved. While their preoccupations seemed to caricature some phase of their education, the attitude toward education was one of disinterest. They were indeed in the full-time employ of one of the parents, and they knew it. Psychological test results were few. The results were related more closely to the different examiners' skill at eliciting responses than to attributes of the patients.

Intrafamilial Relations

All of these couples were unhappy and had been unhappy people most of their lives. Mistrustful of themselves and others, they became disillusioned with one another early in their marriages. In five families the fathers were a part of the home throughout the life of the nominal patient; in the sixth case the boy had been adopted at the age of 10. Not long after marriage all of the wives felt lonely and disillusioned, as though impressed or "shanghaied" into a situation no happier than that from which they had sought relief in marriage. The husbands turned their attentions more completely from the home when children were born. They sought satisfaction from work to replace the kind of mothering attentions they had required of their wives. They showed some hostility toward the child who replaced them in this respect, but greater relief that their wives' complaints about lack of companionship had become less frequent.

Communication. Messages from one to the other seemed de-

signed to avoid acknowledgment of leadership. Therefore, communication tended to be obscure, oblique, insidious, and "double-binding" in nature. The dilemma of the child was expressed in behavior driven by a compulsion to perform repetitively some aspect of the requirements to "be good," but at the same time the behavior was governed by a requirement not to grow up. The way in which they were "out of step" also mirrored the schizoid isolation of the father. In excluding himself, the father retained some individuality—itself reminiscent of childish freedom from authoritarian limits. The father left no room for flight into instability on the part of the child because he himself was the undependable one. Leadership in the aggressive quadrant of our diagram was the function avoided by all and, by virtue of this default, it was the role in which the sickest family member was repeatedly cast. When a team member reminded Mr. Birge by telephone of follow-up plans to visit their home he replied, "Bonnie wouldn't want it that way." The team settled for a clandestine meeting with the parents in a nearby town.

Mothers also led—but by indirection. Their basically rejecting attitude toward anyone who placed demands on them was the insidious element in all communication. The children did not learn trust from them, only that it was dangerous to make demands inconsistent with their mothers' needs. Communication was rated as oblique because people in these homes avoided talking directly to each other. They let their views be known through third parties who relayed distortions of the message, or they responded nonverbally to direct communication by, for example, failing obviously at the task performance requested. When Mr. Kemp requested the hammer, son "obliged" by bringing the screwdriver. In response to mother's enjoyment of preparing food, Matt would eat only factory-prepared food.

Fathers. Outwardly these families seemed typical for their communities. The two fathers who were farmers worked the soil as their parents had taught them and for a long period after marriage worked under paternal supervision. The other four had not really

reached the occupational level for which they were trained. The doctor was unable to pass a competitive examination for a military commission just before World War II, and was for a long time in danger of being drafted as a private. The machinist with three years of college had worked for ten years as a machine operator. The economist worked in industry but "refused" salaried positions, preferring to identify with labor. Mr. Mullins hoped only to earn a living from day to day so that he could go hunting. Thus, all were seen by their neighbors as unremarkable but dependable providers, while by their own standards they were economic failures. They were highly schizoid men who were uninvolved or minimally involved in community affairs. All had compromised their working situations so as not to need skill in interpersonal relations. They suspected employers and employees alike. Indeed, they trusted no one. Each one married with the obvious intention of getting someone to perform chores which they regarded as woman's work.

Mothers. The women generally had been younger siblings of formerly prosperous families that had suffered economic reverses. They sought relief from exploitation in marriage. In her way each was self-centered. They were gratified by the team's interest in their personal lives and vented bitter feelings about having found that the spouse was not as he had appeared, someone who could make up for the unhappiness of the past.

Matt Kemp's mother is a competent Slavic housewife, whose present life seems a prolongation of her Cinderella-like past. The only daughter of her widowed mother, she remained at home while her brothers married and moved away to establish homes of their own. At about the age of 20 she married a handsome but unimaginative man five years her senior, who won the approval of her mother and brothers because of his abstinence from youthful folly, and possibly also because he was willing to work the land which his wife's mother owned. Each partner in this marriage was apparently hoping for emancipation from parental domination and for security in the other, and each was disappointed. The matriarch remained mistress of the house and land; Mrs. Kemp found that her Prince Charming was not the go-getter she expected. He neither provided the house and land for them to make a

home of their own, nor extended the family domain by securing additional land. He was content to continue, like a hired hand, to till the soil and tend the cattle on her family farm. Mr. Kemp in turn found that he had exchanged the domination of his parents for that of his mother-in-law, and he became through the years more and more demanding and critical of his wife.

The symbiotic relationship of these schizophrenic patients with their mothers was more mutually consuming than that between the autocrats and their mothers. It served to suppress the women's resourcefulness. They were less able to see their sick child as other than an aspect of themselves. The child in turn did not struggle with the insult to his individuality. He showed more desire to possess than to punish when he finally sensed the danger of abandonment. Prolongation of the symbiosis aided by flight from reality appeared to have been the only workable solution for these children of lonely narcissistic women. Since they felt little trust in their ability to cope with life, these mothers molded and coerced one child in a way that seemed to assure them of total control.

The Nominal Patient. While the autocrats studied people in reality for handles by which to manipulate them, the psychotic youngsters in our series preferred to behave as though their wishes were reality. A difference in what they could trust was involved. Evidence that the autocrats placed some trust in their importance to others came from the regular use they made of the threat to absent themselves in order to make the significant person sorry. The more infantile group, however, had not ventured forth enough to know so clearly the difference between controlling someone and being a part of someone's pattern of living.

Throughout our first year's work with George Milton and his family, the patient behaved as though the team were his consultants on problems related to producing his cartoon movies. He accepted all criticism and opposition somewhat patiently as the failure of others to recognize his genius. He expected his family eventually to turn all their efforts to furthering this cause. He assumed that the team's work with his parents was directed toward reducing their resistance to investing in a movie projector and a trip to Hollywood. Both of these requests were granted,

but he managed to use them with sufficient ineptness to prolong his privileged treatment as psychotic or infantile.

Success in terms of adult approval of their projects, like reassurance, was not trusted. They behaved as though approval was a manipulation designed to prove them less deserving of other people's time. If parents approved an act, the patient repeated it until it was no longer bearable so as to prove that the approving persons were insincere like everyone else. Theirs was a failure to establish any basic situation of trust.

Matt, since the beginning of second grade, had refused to play with other children at all. He played by himself, watching ants and bugs. If other children came to him, he would leave to continue his observation elsewhere. His unfriendly ways continued as his psychosis developed into bizarre behavior that revealed a particular distrust of mother. Since the age of 12 he had felt that everything was dirty. He had to have a special set of silverware and dishes which he alone washed—each piece separately. Rather than eat his mother's bread, he insisted on a sliced, wrapped loaf from the store. He then broke the wrapper at the middle to drop one slice on a paper napkin.

Sibling Situation. In three cases where the schizophrenic youth was the oldest, the pattern that produces the "well sibling" occurred. In contrast to the situation in the family of the autocrat, the young sibling of the schizophrenic youth was not intimidated by parents who could not grant individuality; he really escaped intimidation. The younger child's birth had resulted in an exacerbation of the older child's efforts toward his mother. The division of labor which naturally resulted made the father, already somewhat excluded, companion and "mothering one" to the sibling. The sicker older child seemed to draw to himself most of the anxious and pathological reactions of both parents, leaving the "well sibling" to externalize the more conventional values. When the more infantile older sibling was removed from the home and the "well sibling" became the target for exploitation, he tended to respond, appropriately for his further developmental progress, in a preadolescent way by rebelling.

In two families the schizophrenic adolescent was the only child. In the fourth family the adolescent patient was the second of four children.

Matt's older brother had been reared under the maternal grandmother's supervision. This lady acted as though she owned the place and as though the Kemp family were her employees. When Matt came on the scene, his mother badly needed something to call her own. As the grandmother aged, the older brother was freed to become the "well sibling" who shared his father's exclusion from the more recent mother-son relationship. Two younger sisters were born and thus held legitimate title to privileges of infancy and childhood. Matt apparently closed his eyes to reality to hold on to his privileged relationship with his mother. Indeed, the obsessive-compulsive features of his illness suggest that there was a substantial effort to use symptoms as do the juvenile adolescents, where the ability to compel relationship with the mother was otherwise less effective.

Family Constellation. These families interacted almost entirely from extreme positions of specialized functioning. Fathers were not, as in the families of the childish youth, dependable observers and critics. More extreme exclusion combined with schizoid personalities to make them quite unreliable and capricious. In this way the fathers reserved for themselves the functions of the emotional instability quadrant (Fig. 4-4). The youths in these families differed from the childish group in this lack of recourse to even the

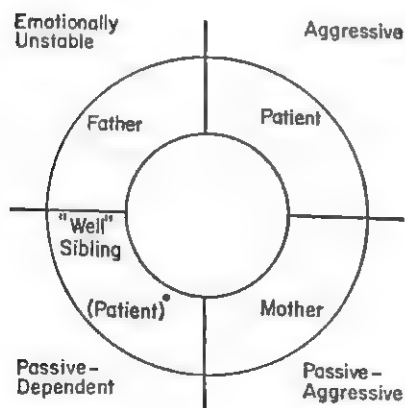


FIG. 4-4. Family Constellation for Infantile Functioning in Adolescence.

* Parentheses indicate role outside the home.

pseudo freedom of instability. The role structure served to keep them dependably in the employ of a needy parent, the mothering one, who did not take overt leadership, but forced the youth to exercise family leadership (aggressive quadrant). The extent of the pathological condition corresponded to the discrepancy between leadership requirements and the suitability of the adolescent for that role. Outside the home the schizophrenic child generally behaved with passive indifference to others or repelled them. Healthy aspects of the extruded parent are not clearly indicated on this chart except by the inference from the location of the "well sibling" on the line between the passive-dependent and the more spontaneous quadrant. The position also cuts into the central circle (of relatively open system functioning). This position on the chart reflects the background of relationship between the well sibling and healthier aspects of one parent.

Crisis

The situations in the families of schizophrenic youth were much more chronic than in the other families of our series. The patients were reasonable candidates for commitment to inpatient care. The families came to this medical center hoping to extrude the member who manifested the family illness. The real crisis was still latent but was sensed by all. It was the conflict over who was to lead when the effective leader was removed. This proved to be a useful handle for therapy and made it more apparent that growth for all members of the family would be more possible if the problem were undertaken while working toward inclusion rather than exclusion of this crucial family member.

SUMMARY

We have described four family syndromes which seem to differ according to the family's ability to allow its youth to pass through several developmental epochs. These family patterns came to our attention as we attempted to account for the failure of the youth at crucial developmental tasks. The troublesome behavior of the

adolescent appeared more clearly to be a natural effort to cope with his situation when the particular arrest in development was considered.

The family syndromes are labeled according to the arrest in development of the member whom the family presented as the patient as follows: *families presenting* preadolescent functioning in adolescence, the *rebels*; juvenile functioning in adolescence, the *intimidated youth*; childish functioning in adolescence and preadolescence, the *autocrats*; infantile functioning in adolescence, the *six schizophrenic adolescents*.

When the chart is used to diagram the relationship, the four arcs that form the circumference of the outer circle mark the extreme position in each mode of immaturity. A person charted graphically near the outer edge of the circle then relies inflexibly on the associated immaturity reaction. The modes of immaturity and their location in the graph are: upper right, the aggressive way of influence; lower right, the passive-aggressive way; lower left, the dependent way—the power of the weak; and upper left, the emotionally unstable way—control through being unpredictable (Figs. 4.1 to 4.4). Our rebellious youths are usually located in the upper left. The “well sibling” is often located on the line between the two left quadrants. Optimal functioning, implying the ability to perform the normal functions associated with any of the quadrants as need arises, is expressed by locating the person toward the center.

Thus, we studied the families with respect to flexibility in role and function. Could the father, for instance, take leadership when it was called for—function in an aggressive way? We were also interested in whether he could relinquish leadership and function as a participant observer. Constructive criticism is the healthy aspect of passive-aggressive functioning. To a certain extent an adult, even in a position of leadership, must be able to relax and be cared for when ill without excessive denial of dependency needs, i.e., be able to function in a passive-dependent way. He needs also to be creatively playful in times of recreation—the normal aspect

of unpredictability; this capacity is located graphically in the quadrant which has emotional instability as its pathological extreme.

The use of this conception of family interaction to guide therapy, and the ways in which the paths through the multiple interaction methods differ according to the four types of families, are illustrated in the next chapter.

CHAPTER 5

Family Dynamics and Therapeutic Movement

Multiple impact therapy is an attempt to stimulate self-rehabilitation. Since our observations are largely drawn from intact families and our intention is not to theorize far from what we studied, our methods and theories have to do with assisting families to realize goals within a value system weighted in favor of integrity of the family.

We have observed that even in families which are not intact and in families of other social classes, the values of the middle-class intact family continue to have greatest currency. As in the theory of the myth in history discussed by Cassirer [1], the influential fact is that the population behaves as though this idealized picture is what should exist. This fact, the consistently expressed wish of men, gives sufficient significance to the conventional family value system to suggest that the dynamics behind its values have survival value for men. It is perhaps the basic compatibility with the facts of man's existence that accounts for the survival of Freud's observation on family dynamics and the family romance. Thus, we do not feel unabashedly naïve [2] when it becomes obvious that most of

our therapeutic maneuvers are derived from the principle of making the family romance come out right.

In this chapter some considerations about therapeutic strategy with families in general are followed by discussion of work with particular family members. The direction of movement of parents through MIT is discussed in the sections which follow the general considerations. In each of these sections the experience of the father is taken up first. This attention duly reflects the team's emphasis and the observation that his role in the health of the family has been neglected.

While Andry [3] views the overemphasis in child psychiatry on the role of the mother as having followed from Bowlby's influential work [4], we viewed the overemphasis as in part due to the fact that the mother is more apt to be present during the referral and is more apt to let the doctor know that she is suffering from the immediate crisis. Our multiple interaction methods require the father's presence, and he was usually encouraged by this regard for his importance to his family.

Following discussion of work with fathers, the way the mother experienced MIT in each instance is discussed in terms of the relationship and therapeutic work with her husband. After the consideration of work with parents in general, the same pattern is followed in presenting the direction of therapy with the families of each type; the schizophrenic and the childish youth, then the families presenting juvenile functioning in an adolescent, then the families of the rebels. The course of treatment through MIT is then recapitulated in a section on the movement of the adolescent and summarized in terms of convergence. Convergence refers to the way team members and family members arrive at consensus concerning operational statements of family dynamics and plans for the resolution of problems. A final section on follow-up work illustrates the various therapeutic tasks which are part of MIT but occur after the two-day procedure. Indeed the two-day work may be a *rite de passage* to the effects and further work described in the last section of this chapter.

SOME GENERAL OBSERVATIONS

Benefiting from the methods of psychoanalysis, we have learned not to be preoccupied with the obvious, nor to overlook the special meaning of obviousness. As Freud mentioned in "Family Romances" [5], children make continuing comparison between their own and other families. Significant matters, whether discussed or not, thus show their outline. So it is with family secrets. They are known in some measure by all but there is a collusion not to speak of them. Typically, the family sought first to enlist the team in this collusion. The team's success in dealing with these matters as "too important to be silent about" was crucial in determining whether the team-family interaction was constructive.

Collusion, which the dictionary defines as cooperation in a fraud, is here generalized to refer to the defective communication system by which parts work together to exploit the whole. This is a system which ostensibly uses the formal rules of public morality while operating in fact by the informal rules of private morality. Publicly, we make rules to foster economic competition, while privately, gentlemen agree not to invade each other's markets. With formal logic Darwin showed that the most vigorous competitors are the fittest to survive. Noting the interdependency of living systems, Kropotkin [6] used the same data to show that "the fittest to survive are those best able to render mutual aid." So it is within families. Competition between parents and between siblings, and hostility toward others and from others: these are the things that can be talked about with consultants, who, like the team, are relative strangers, albeit entitled to officially privileged communications. But love, tenderness, and collusion: these are matters that, when discussed by defensive people, lack the setting necessary for real intimacy. These are the real secrets which are not discussed but which may be externalized by a member of the family through symptomatic behavior. Thus, we have learned to be alert in sick situations to secrecy, complementarity of goals, and collusion rather than competition, and to regard competitive behavior as an activ-

ity of well-integrated personalities whose emotional economy is centered in mutual consideration.

Such complementarity is illustrated by the way in which fathers in many of these families have participated in their own exclusion. Rather than charting our approach from his complaint that his son, by virtue of a close relationship with the mother, excluded the father competitively, we looked at the way fathers, doubting their own adequacy, encouraged their children to take over the task of keeping the mothers occupied.

In situations of sibling rivalry we have been attentive to the way in which an older sibling, as in families with a childish adolescent, may resign his privileges of seniority to a more dependable younger brother in return for prolongation of the privileges of childhood. The family, however, characteristically reports reacting anxiously as though the older child is losing in a competition with his brother. The usual failure of the futile attempts by parents to restore competitive advantages reinforces the observation that it is the collusion, not the competition, of which all are unaware. The well sibling often gains respect through expressing the socially accepted values and, as Juliana Day [7] has observed, may thereby sacrifice the development of some of his creative potential; while the nominal patient achieves significance through absorbing and expressing the more primitive pathological processes. This pattern was illustrated in the study of the Mullins family (pp. 121-124).

Rotating Depression

The movement of families through therapy, the way therapy evokes expression of pathological processes, and their relation to natural processes was illustrated in many cases by what we have informally called "rotating depression." While this has implications for theory concerned with homeostasis and the exploitation of one family member by another, we have found it useful as a guide to therapeutic movement. We view it as part of the process by which a family rids itself of obsolete mechanisms, a natural self-rehabilitation process by which family members return to accessibility to

outside stimuli. It is a cooperative movement from depression through grief where the mourning process serves as the natural model. Preceding each expression of the mechanism of depression was a situation where a family member was faced with evidence that he had lost a valued sphere of influence. The way in which depression was experienced by members of a family can be seen in the following illustration from the Jones family in therapy discussed in a previous chapter.

The presenting situation was one of a depressed and excluded father. His only way of expressing his significance to his wife was by conveying pessimism about his job; that is, his possible inability to continue to be counted on for support. ("You may notice me should my job fold up or when I am gone.")

The father was helped with his self-regard and encouraged to relinquish reliance on vocational achievement as the only evidence of his masculinity. The son became increasingly aware that his fighting and bravado were likewise only a way of appearing manly. He came to realize that should he give up these demonstrative activities, he would be forced either to experience powerlessness or to become depressed.

By resolving the fear of accepting limits set by others on his powers and by identifying with his father, he knowingly, but with some expressed compassion, risked his mother's becoming depressed. When his mother saw that she was threatened with the loss of this mainstay to neurotic power, she became in fact depressed but remained responsive to the affection of the other two members of the family. She showed that the depression had a favorable prognosis by a cheerful and playful threat to sue the team for any breakup of the family.

THERAPEUTIC STRATEGY

Before considering the way in which therapy progressed for each of the four types of families, we shall examine some matters of team-family therapy that we have found generally applicable apart from typology.

Group Therapy Technique

Probably similar in its group dynamics to the "rotating depression" observed in families is a danger signal useful for detecting

when the team is working unprofitably. "Team euphoria" is the situation in which all of the team members seem to be elated concerning the progress of the case. When the work is going well, at least one—and this rotates among the team members—is quite pessimistic about the family, if not discouraged, and may campaign for "limited goals in this case." When none are discouraged, the team quickly checks to determine whether the euphoria is not defensive because all are discouraged. The situation may be easily tested by review before a disinterested party or consultant. When the euphoria is defensive there is a glaring scarcity of data. Vigilance in this therapy, which demands so much personal involvement, is necessary to keep the team from simply turning its procedures on itself in a false morale-building move. A team in another medical center, not familiar with such pitfalls, tried the method with a hospitalized psychotic patient whose subsequent suicide may have been due in part to his feeling that the team members were more attentive to each other than to his needs. Feeling that the work had gone well, the team furloughed the patient to an ill-prepared family.

We have not written separately of transference, in part because it is examined along with the relevant typology and stage of therapy, and in part because it is analysed continuously rather than at a particular stage of family therapy, and it is not a separate problem. The team euphoria mentioned above is illustrative. In conventional group therapy there are for each patient multiple transferences to several group members who may temporarily occupy family-like roles. In family therapy, where the people of concern are actually present, we moved even farther from the classic psychoanalytical situation where the patient and analyst deal with transferred phantasms of people. As a control we have found it useful for our therapists also to be engaged in individual therapy where there is the contrasting opportunity to study against a constant frame of reference—the doctor—the multiple personifications with which a single therapist is endowed by transference.

As group therapists, we handled some MIT situations very dif-

ferently from the way we would have dealt with a continuing therapy group. Where one of the parents was able to use group situations to speak freely to the disadvantage of less expressive members of the family, the team spoke up for the less expressive one. This has been said to approximate the technique called "doubling" in psychodrama [8]. For the expressive member of the family, provision for a better hearing was made in individual sessions. The strategy here was to prevent him from using the group to make speeches that could intimidate the family members into feeling hopeless about their chance of a hearing.

The team-family conferences were not simply free discussions; they were attended by a number of therapists who, as MIT proceeded, developed increasingly specific objectives which had been defined in a series of conferences concerning the case. The pursuit of such objectives seemed to enhance the confidence of the family in the competence of the therapists, and also it eliminated much of the waste of time and additional anxiety experienced by patients who, though cooperative, could not define their part in the work.

We have found it particularly important to keep separate conferences between team members to a minimum. Where possible, changes in plans were discussed in the presence of the family. Supervisory comments to staff members from a senior staff member can often be worked into the context of the meeting. The advantage of this procedure is that it improves the patient's understanding of what is happening and cuts down the natural distrustful feelings that collusion rather than convergence is the basis of agreement on interpretation. On the other hand, too much direction of therapy of course promotes resistance. It is now our impression that the team may rely on the impact of the first-day session of MIT to stimulate thoughtful consideration and communication among various family members during the first evening. It is not impossible that a direct request that the family discuss the day's work tends to mobilize resistance.

In the earliest cases of this series, the team and various team members became impressed with the quantity and quality of com-

munication between family members during the luncheon break on the first day and overnight between the two-day procedures.

In the Helson case, there was emotionally significant communication between parents during the lunch hour. Mr. Helson reported to the social worker after lunch on his wife's comments about "in-law trouble." He also reported his wife's preference, expressed to him, to talk with a male team member. This was especially notable because the family were advised to "enjoy themselves" at lunch and not get into the kind of discussion that leads to hurt feelings.

There was no parents-team or family-team conference that afternoon, and no recommendations or injunctions to "talk things over" that evening. Shortly after leaving the office that first day, in fact, they were able for the first time to talk openly of recurring irritations about each other's small foibles. Much repair of broken communication was done overnight. The parents found themselves much more able to discuss matters and had for the first time in years a satisfying sexual experience.

Encouraged by similar occurrences in several families, the MIT team adopted the practice of recommending "homework," family conferences over lunch, even "arguments." Frequently when these suggestions were made, the family did not follow them.

When the Veats family told of their economical arrangements—parents and both children in one room with cooking facilities in a cheap hotel—the team strongly recommended at least two rooms to give the parents some privacy, but the recommendation was rejected. Similar but less direct suggestions were made to the Sutters, the Joneses, and other families about parents' having time and opportunity to discuss things privately, and the suggestions were not followed. Families allowed movies, television, visiting friends, and other distractions to interfere when they did not openly and verbally reject the suggestions.

Success in MIT, as in any form of therapy, seemed to clinicians who participated as consultants or visiting scholars to be associated also with the confidence of the team members in each other and, in each case, with what appeared to be an innovation, some creatively applied technique. The serial use of overlapping sessions, now a regular practice when resistance is massive, began as a move

of desperation. As a standard technique, it would be excessively manipulative unless the new insight to be relayed from room to room had genuine news value.

In a manner familiar to group therapy, the team usually allowed initial pleasantries to continue until their theme or function could be described. Then with this data accessible to all, the superficial layer of resistance was studied. This initial resistance is often a piece of the larger problem of resisting recognition of the relationship between actions and meaning. In short, we told the family to join us in getting down to work by a demonstration of the work.

At the opening of the first team-family conference, Mr. Forester sought special favor from the psychologist by saying he had raised his test score 25 points on retaking the army test. The psychologist complimented Mr. Forester and explained to the group his own high regard for the reliability of that test. The group continued for a while at a sociable level, during which team members asked about the father's technical level of employment and discussed the significance of aptitude. Robert, the nominal patient, asked why we were assembled. Mrs. Forester apologized for what she said was her son's limited ability to understand technical words. The psychiatrist defended the boy's question, noting that it appeared that we were just visiting about army experiences. At this point the boy defended his mother's remark, saying he had lost some of his memory in treatment at another hospital. The psychologist then described the foregoing process to the group, underscoring particularly the initial interest in Mr. Forester's achievements. He asked whether the pattern of mother defending son and son cooperating with mother often works to exclude father. Validity of the observation was betrayed by the way Mrs. Forester giggled and called us "nosey." Her son, sharing the feeling of being caught, suggested "more care in talking before a tape recorder." Although the father denied much absence from the home and professed helpful intentions, the son indicated that he hardly noticed his father's presence "until I do a little wrong." This implied a claim that the father participates only when the son invites it. A team member suggested that the son is forced into leadership by the default of others.

Thus all were assured by the team's behavior that they had excited the interest of team members. The content flowed from the

need of the family members to document or refute the interpretation of the interaction.

From the outset the team used the genetic approach to understand patterns of behavior, thereby deriving an understanding of the present problem from a review of its early life origins. When the family tried other avenues of explanations, the team dealt with the attempt as with a resistance. Where the parents of the intimidated children rushed into the recounting of early life events as a defense against study of the present, the families which yielded children arrested at infantile and childish levels initially resisted a genetic approach.

When Mrs. Forester attempted to explain away her husband's non-participation by saying he had varicose veins and worked standing up, the team felt she was not defending him as much as explaining away her own inability to charm him back into her life. Their response enabled her to reveal the story of how she had always worked outside the home from the time she was young because of loneliness. When the husband denied that he was left out by claiming to have helped his son with studies, Robert dismissed his father's claim to helpfulness as being typically a gruff suggestion that he "look it up in the encyclopedia." Mrs. Forester attempted to prove herself more dedicated to meeting the child's needs and added that this had replaced work in her life. Incisively the boy suggested she get a job. The team called attention to the seeming cruelty of the remark and also to the problem of her being so much at the child's mercy.

The next morning both parents presented data from their life histories which helped them understand their own repetitive patterns. Since the Foresters are the family of a schizophrenic patient, the individual sessions immediately following the initial team-family conference were spent in further validation of interaction patterns noticed by the family at the clinic and in the recent past at home.

These families took much more time than others did to satisfy themselves that they could be understood, that the therapists separately were trustworthy, and that individually the team members were what they appeared to be in the group. The four types of families differed in respect to the readiness with which the relevant life history material was forthcoming. They differed roughly in

the same order as did the levels in development arrest. Thus the Dyal case appearing in Appendix A is at the opposite extreme from the Forester case. The genetic approach to understanding in the Dyal case—that of a rebel—was facilitated at intake.

Another general aspect of strategy which we discovered in retrospect by listening to recording of the work is that the team leads the family in the expression of affect with the families of infantile and childish youth. With these families the team is relatively more demonstrative than the families in expressing attitudes. In dealing with the families of the intimidated youth and more so with the families of the rebels, the team is much less demonstrative than the families. The families of the last two types provide the histrionics while the team shows a reserved, even at times skeptical, attitude.

Therapeutic Strategy with Reference to Specific Family Members

MIT seemed particularly a way of gaining the participation of ill-motivated family members.

Fathers. The fathers came with little expectation that they would be participants in any change. This attitude prevailed whether the father's remoteness was associated with exclusion because of his own default, or was caused by a too close symbiotic relationship between mother and child, as in families of the more childish youth. It was present whether the father's remoteness resulted from his aggressive façade, as in fathers of juvenile adolescents, or from his elevation to a protected pedestal as the family's show piece, as in families of the rebels.

Fathers had often avoided child guidance clinics because their wives conveyed an impression which threatened already uncertain feelings of manhood, and they surmised that treatment would somehow lead to their having to function in areas they deemed to be the province of women. Yet from their detached vantage point they were found to have made rather keen observations on their families. Frequently their presenting attitude was that their part was to chauffeur their families to Galveston. With the exception of

a grandfather acting as a father, who had to be interviewed in his station wagon, all were enlisted to participate by attendance at the opening team-family conference of MIT or in a prior intake session, and they participated actively throughout.

Typically the fathers underestimated their influence on their children and their own importance in child rearing. In general, the team was able to demonstrate that, whether by default or action, the father had a more significant influence than he had suspected on his child's behavior; that the troublesome behavior of the child could be viewed as an expression of the father's own unexpressed values.

With the intensity usual to the family of the intimidated youth, a mother said in the opening conference, "I do want you to help me get my husband to make some of the decisions around here and to make them in a way I approve."

The father's participation was clearly a response to the team's recognition of his importance, although his physical presence might be attributed to the greater feasibility of scheduling a two-day trip rather than keeping regular appointments. In the opening team-family conference he was recognized for having brought his family to treatment, for being concerned about or plagued by his child's behavior, and for having had a determining influence in the family troubles as well as fortunes. His observations were often accorded special respect because of the position of detachment from which they were made. His very presence was treated as evidence of constructive intentions toward his family. The work was, in general, in the direction of helping him define a position in his home that enhanced that of his spouse without necessarily increasing his participation in the mothering function.

We were repeatedly impressed by the fact that, while conscious complaints often referred to unfavorable competitive experiences in the family, rarely did any family member refer to the ways in which he participated in keeping himself in an ineffective position. Tender feelings, like collusion, seem much more difficult to notice because their expression is frowned on more in our culture than is expression of competitive motives or harsh feelings. The manner

in which the father's participation was engaged in this therapy included a delay in investigating his part in the exploitation of the child. First he had to be helped to accept the idea that he was much more important to the child and to his wife than he had realized. It was usually only after he showed ability to recognize his wife's unmet needs for tenderness that discussion with the father of corresponding needs on his part was attempted. Similarly, it was often necessary to "keep things on a comfortably hostile plane" with the adolescents until they gave some sign of readiness to talk about tender matters. In discussing management of schizoid and obsessional adults, H. S. Sullivan [9] recommended such an approach, and he attributed its necessity to uncompleted developmental experience in preadolescent years. Thus MIT is supportive of fathers in the sense that stress is placed on their potentially greater importance, and that understanding but not acceptance is given their presenting situation. It is gentle rather than assaultive, particularly because impact occurs in a context of support.

Mothers. In the initial team-family conference the team regularly gave open recognition to the fact that the mother is entitled to be more on the defensive than the others. The fact that she brings a problem child includes some insult to her motherhood. The attitude that this may be associated with marital problems often includes feelings of failure as a woman. Referral itself appeared to cause less acute insult to the father, because in our society manhood is outwardly evaluated in terms of man's occupational success. The wife's dilemma was often discussed in terms which revealed the kind of recurring patterns the team sought to bring into awareness. Nagging often provided the example. The team's attitude was that nagging, or repeating a predictable unsatisfying pattern of ostensibly helpful criticism in a way unacceptable to the recipient, results from a paucity of more satisfying avenues of adult emotional expression. Women do not enjoy it; indeed it hurts their self-esteem. They find it necessary where other avenues are closed. Attention was directed toward an associated problem, which was that mothers were more at the mercy of their children because of their need for emotional outlet and vindica-

tion of womanhood when, as outlined above, emotional closeness with the husband was impaired. Team members showed frank alarm at the possibility that, because of her preoccupation with the problems of a limited youngster, the mother might cease to grow in capacity for interest in adult matters and, in fact, was in danger of becoming quite a bore to husband and friends.

Second Session

The opening team-family conference, a group session, was followed by concurrent individual sessions. When the number of persons in the family was larger than that of the team, two or more younger children were seen together.

On many occasions the basic team was expanded to include one or more extra members such as a community representative, visiting therapists, consultants, or students. When the size of the team exceeded the size of the family, one or more auxiliary team members joined a basic team member in a conference with the father. This plan emphasizes our desire that the head of the family participate in leadership functions. It has been particularly useful when the mother seemed to have absorbed most of the initial impact.

Fathers. The father was consulted particularly about the way in which the opening group situation may have reflected recurring patterns within the home. The group was usually narrowed to one interviewer when the others had developed an idea that might be useful to carry to another office, or when it appeared that the special problems of enlisting the father's cooperation were no longer helped by their presence. Rather than a "bull session" atmosphere, there was generally an air of urgency provided by the team member's need to get a better understanding of special sensitivities already shown by family members. Seriousness was also contributed by the father in his urge to have the team members realize that there were respectable reasons why he may have appeared less than adequate in the opening conference.

Mothers. The initial team-family conference was usually followed by a session between the mother and the female social

worker. This plan was decided in part because the mother is often a better informant, and in part because the social workers are more adept at gathering and organizing family data. Deviations in the procedure appropriate to the various types of families are discussed below.

When it had been decided that an overlapping session was to be held with the mother, a therapist who had had a brief interview with another family member telephoned later in the morning, requesting to join the social worker and the mother. On his arrival the social worker reported to the incoming team member the gist of the interview with the mother. The incoming team member responded by showing how the behavior of the one he had interviewed, usually the adolescent or the spouse, was logically related to the behavior patterns elicited by the social worker. He could allow himself to be quite matter-of-fact concerning his impressions of this patient's relationship with the mother because she had with her a worker who could respond with equal candor on behalf of her patient. "This makes very good sense in terms of what I have been hearing from your daughter because your whole view of adult married life, as she hears it, is of drudgery. Small wonder that she has learned from you to reject competence in those areas where you are so proficient, such as ironing and housekeeping. You feel unimportant to her when you can't get her to work, but you are indeed very influential in steering her away from the desire to become adult."

In such situations the social worker supported the mother against the incoming therapist, using the special closeness that comes from the fact that the two are women and have just been through difficult experiences together. (See p. 32: MRS. RITCHIE: Let me speak up for Mrs. Jones and what she is missing! At this point she feels terribly deprived of the support of her husband. . . .)

Afternoon Session

In the afternoon the mother saw a therapist who had prepared himself for the interview through the morning's interview with her husband. At a luncheon conference this therapist had an op-

portunity to express and examine with his colleagues any special prejudices he may have acquired. At the afternoon interview he let the mother share his impression of what she had been up against through the years with her husband. This sympathetic view helped relieve her of the feeling that since her husband had spoken first, she was already judged. Further diagnostic work with the children during this afternoon was used to excuse the team from extensive discussion of the children at this point. It also served as an excuse for close attention to the parents' lives even though they may have said that they only came to see about the youth. Recurring problems in the marriage, faults in the communication pattern in the home, and the likelihood that the sexual relationship too reflected defects in interpersonal patterns were considered. Overlapping sessions from therapists who had had joint participation in interviews with other family members brought to the mother, as she joined the first day's final team-family conference, the evidence that old defenses might no longer serve.

The day's investigative work often led the family to expect that in the final conference of the day the doctors would reveal the treatment plan, or recommend hospitalization of the youth or a special regime. Instead, the family found that they were expected to spend the night in town together, knowing that each had been making a study of his own patterns in relation to those of the others. Mothers of antisocial youngsters generally showed some signs that they were going to be very difficult. Such a hastily erected barrier to communication was countered by the psychiatrist by a promise of an individual session with her at the beginning of the next day. Reports of that first night of MIT indicated that the parents behaved as though newly aware of themselves. They experienced an awkward feeling of lack of defenses in each other's presence.

EXPERIENCES OF FAMILIES OF SPECIFIC TYPES OF PATIENTS

In addition to the general therapeutic strategy with father, mother, sibling, and nominal patient, this study has developed

somewhat different paths through MIT for the family members of each of the types of families described in Chap. 4. Definition of the several problems that yielded a certain type also calls for treatment methods specific to the type; this is evidence in support of the usefulness of diagnosing families by this scheme.

The mind of the therapist in MIT is continually focused on the idea that any constructive steps taken are only beginnings of processes that must endure because they have a more economic and natural appeal than the unsatisfying ways of behavior the family has been using. The presenting picture is conceived in the ways described in Chap. 4 and may be graphically summarized by the circular charts. MIT then is planned largely as an approach to an initial objective, from which point change will follow by the family's natural processes. Satisfactory movement in each case would be shown on the diagram by locating the individuals closer to or within the central circle (Fig. 5-1).

Families of Infantile and Childish Adolescents

The approach to the initial objective with these families was an effort to increase the husband's activity, particularly in support

Diagram A The Six Schizophrenic Youths

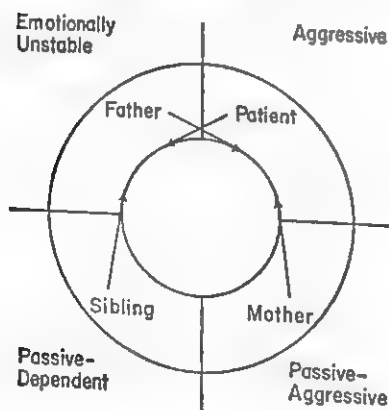


Diagram B The Autocrats

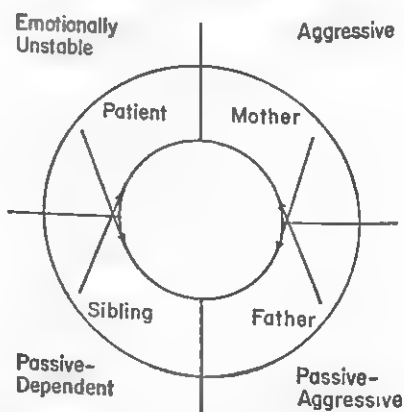


FIG. 5-1. Approach to the Initial Objective in the Families of Infantile and Childish Youth.

of his wife. In the families of the schizophrenics the father was encouraged to take over more of the emotional load of the child, allowing the mother to get a job or find a more reassuring basis for her self-respect than that which could be immediately supplied by her schizoid husband. In contrast, in the families of the autocrats, the less schizoid husband was encouraged to avoid such direct supplementation of mothering functions because he could meet his wife's need for appreciation. Graphically considered, the approach to the initial objective with the autocrats involved the husband's displacing the wife from the leadership position, while in the families of the six schizophrenics it involved the husband's displacing the child from leadership.

Fathers. With the most excluded fathers, the task was that of working with them to the point where the first afternoon's team-family conference might give some evidence to the wife in support of her desire to change from depending on a child for emotional release to reconsidering the dependability of husband's influence. Obviously, to a person whose life is not going well, simply supportive measures would be short-lived. However, the presenting adjustive processes of the family were viewed by the team as unsatisfying because of failure to take into account the factors that produced unhappiness. Unwitting participation in an unsatisfying adjustive pattern was usually found to persist as a defense against exposure of presumed inferiority. Much of the neurotic interaction in the marriage seemed to consist of mutual threats to expose weakness in the spouse. The "weakness" was one that would matter only if the true values were competitive. By pretending to recoil from unfair competition—insult to masculinity—the husband had attempted to justify his retreat.

Mr. Linton complained that every time he tried to supervise his son's activities by setting limits on availability of money and of the automobile, his mother-in-law and his wife undermined his efforts by indulging the boy's whims. "I just gave up—they felt they could do the job better."

The team responded to the culture-wide problem of equating

tenderness with weakness, and to the defense of replacing a tender relationship with a competitive one.

Here again, the defense took the form of ostensibly defending against a publicly sanctioned problem—competition—while the secret problem had to do with collusion and feelings of inadequacy in relation to tenderness. Instead of attacking the defense, the team advocated expression of tenderness as something that took courage. This appeared to have more impact when demonstrated rather than lectured. The following illustrates a way in which an expression of tenderness was evoked in several cases.

One therapist reported to Mr. Kinser that in an individual session Mrs. Kinser had shown real charm when the therapist expressed alarm that one so attractive should busy herself only in devotion to the younger generation. Kinser responded by mobilizing some courage in the final team-family conference of that first day to say that his wife's attractiveness had improved, possibly because of their marriage, but this was not what he brought his wife to see the doctor about. The rest of the team gave recognition to the father's changed attitude in pointing out that he had come to the defense of his marriage.

The desire to change was also furthered by showing the parents how the psychosocial arrest in development of their child was in part a response to their own fear of exposing themselves to competitive evaluation at home. The argument here was that the child's failure to test his real abilities by association with others followed from the way the parents acted out their own fear that to become known was to be found wanting.

The following is an example of the team's way of responding to such irrational feelings of inferiority. In the opening team conference the father frequently expressed ambitions for the child in some form indicating that from early years he had urged the child not to emulate him but to become something better. "Daddy didn't need a college education to make his way in the world, but you do." Restated in this way by a team member, the implied insult to the child is a little clearer. The team pointed out to the parents the way preadolescents tend to idealize their model, pick-

ing the strongest and most regularly reinforced attributes and neglecting the inconsistencies. It is possible to demonstrate that where the father tends to disqualify himself, the youth selects a caricature model, such as an Elvis Presley. The parent is reminded that from the growing child's position the father, with all his actual limitations, is far ahead of the child. Truly, if the child were to become his own idealized picture of his father, he would surpass his father's achievements and education. In this the father could at least hear that he was regarded as a favorable rather than, as he had presumed, a noxious influence on his child. Indeed, he was encouraged not to be neutral but to trust himself to try to influence his youngsters in ways that come naturally to him.

At this time the pressure of his wife's propaganda for him to take over some of the mothering functions could be reconsidered. The team treated this dilemma sympathetically as an aspect of the mother's having been excessively entangled with a youngster whom she could not really criticize objectively because of her dependency on him. Her husband was enlisted in the process of disentangling these two, not by serving her more, but by a more obvious pursuit of self-interest.

When Mr. McLean indicated considerable frustration at attempts he had made to get involved in the games that interested his son, he was encouraged to admit that it was fraudulent for him to act as though interested in the things that occupy a young adolescent. The therapists proposed that it would be more possible for the boy to want to grow to manhood if he could respect the genuine pursuit of his father's own interest. If Father believed homework was a good idea, it seemed better to suggest that Father do his own homework and be known to accept consultation on it, so that the youth could benefit from the example.

While the husband's default in relation to his wife was the subject of subsequent individual sessions, resistance to its exploration was reduced by the team's attitude that the husband was needed by the wife in a role much more a tribute to his manhood than the kind of supplementary mothering role she seemed to be

asking for. His task was to help her relinquish her aggressive role and to trust his leadership through being able to trust herself to him, a condition necessary for intimacy, including sexual intimacy. It seemed expedient to draw examples from the sexual relationship. This was not to encourage more sexual activity, but the analogy was used because this had often been the one area in which both had tested their own feelings of inferiority. And since it is a private area, it provided the least complicated examples of interpersonal negotiations. Where the sexual relationship had been an aspect of power struggle, the idea that dissatisfaction demonstrated sexual inferiority could be rejected by the therapist, who showed that the situation was not one of intimacy but of power negotiation, or a test situation.

At the final team-parent conference of the first day, movement based on such rapid introduction of dynamic material was not usually apparent. The likelihood of uncomfortable reluctance to rely on old attitudes was high, however. This also gave the team an opportunity to speak for the reluctant ones as they reviewed in the presence of the parents the day's investigative work. The supportive remarks appreciative of the father were expressed, and his misguided efforts to go along with his wife's leadership could be illustrated. Stress was placed on the way the husband might have disproved preconceptions of team members, or on the way he might have spoken in his wife's defense. She had the opportunity to see that others were able to approve of her spouse even though they had also been critical of him. Impact was enhanced when team members were free to disagree with each other vigorously in the presence of the family without loss of basic respect for each other. Strengthening of the parents as suitable models was facilitated by the team's example of healthy interaction.

Mothers. Mothers of infantile and childish youth had all been seriously neglected by their husbands. The very detachment of these husbands made it possible for them, with therapeutic guidance, to turn more appreciative concern toward their wives. By its concern for the mother's lack of emotional outlet, the team set

the stage for helping the youth see that he was more the exploited one than the controller in the close mother-son relationship that excluded father. The team counted on the father's nonparticipant observer-like role to help him notice that they were finding qualities in his wife that made her interesting or capable of becoming interesting. The team could not honestly find such qualities in some. It is sufficient for this work, however, if the team members only conclude to themselves that perhaps no one but the husband could possibly find her interesting.

In the first subsequent individual session, initial attempts to put the blame on ancestors or schoolteachers were often examined. It was not difficult to relieve the overinvolved mothers of these defenses because they really seemed to want to prove themselves the root of all evil as well as good in the family. This desire to prove themselves powerful was shown to be grandiose and related to the way in which reliance on the power to command had taken the place of trust. Hence, it was possible to show that the adolescent's inability to accept limitations imposed by others followed from the model set by the parent he perceived as most influential, the mothering one. Both mother and child suffered fear of unimportance and trusted only what they could command. The interviewer could indicate that this pattern helps one to understand why the husband's response was to be elusive!

In the afternoon individual session with these mothers, there was frequently relief from the morning's impact when the therapists indulged the substantial narcissistic component of the women by expressing concern with their failure to count more on the appeal that won their husbands. (As indicated in Chap. 4, the husbands in this group had all been relatively popular in their youth.) It seemed useful for the therapist to enable the mother to express herself on matters other than child rearing so that he could demonstrate to her that she had other areas of interest worthy of development. This was carried out by allowing the interview to become briefly a "bull session." The therapist for a while, as did the chaplain with Mrs. Jones and the psychologist with Mrs. Kinser, en-

joyed the enthusiasm of her view on a political or social issue. He was then in a position to comment from real evidence that she possessed heretofore neglected abilities to make adult associations enjoyable. With this response he could then view with alarm the fact that she had really joined her youngster in complaining for the father to perform more mothering functions. Here the therapist, having seen the father in the morning, already knew that to a certain extent the father had been hiding presumed inferiorities by letting his child take over the mother's entertainment. The mother then was encouraged to think how she could help her husband have confidence that he might win her away from the child. It has been found useful to imply that already with the husband concern had been shown at his failure to appreciate how important he was to enhance his wife's confidence in herself as a woman. At this stage, the mother may have concluded that the team was advocating greater sexual activity. This misunderstanding frequently served as a vehicle to illustrate that such activity, while the couple still feared becoming known to each other, would be a further example of the kind of acting out which displaces communication and real intimacy.

The technique suggests changes impossible at the moment because of current resistances, and frequently it leads to vigorous denial. The temptations beyond the resistances, however, seem to have been effective in leading the mother to be more hopefully observant of her spouse. The associated heightened awareness of what had been missed in life tended to bring from the mother a flood of early life material in the first session the next morning. For this reason the team-family conference was occasionally omitted on the second morning.

Integration with the over-all family work by overlapping and joint sessions has been discussed elsewhere. For the mothers of these more disturbed youths, a session in the second afternoon with their first individual interviewer frequently provided an opportunity to discuss the work they had done with the others. Often this therapist had an opportunity to witness an attempt to try again the

old defenses, and he could help make the process a conscious one by reacting to it as though the two were reviewing an old drama. Then the mother was ready to confer with her husband again in a joint conference or in the final team-family conference.

Family. The second day typically found these families in the midst of symptomatic behavior. The child had sensed that some loss in his power to command was imminent. The mother often showed signs of depression. The father then became more clearly a useful resource in his family. In many cases a conference was called toward noon between father and child to discuss their dealings with the woman so important in their lives. Frequently this kind of participation became so rewarding that team members withdrew to allow them to further their acquaintance with each other.

As was evident in the Jones case, a crucial task in the afternoon was that of helping the mother see that the balance of forces in the family was not an alignment against her. The natural process used as a model was the grief process. The fathers had had more experience with relinquishing power and could accept their wives' use of depression as a way to delay recognition of the fact that some powers were denied them. Where the mother could be given adequate support by the husband so that she could experience grief instead of defensively becoming depressed, she was then able in the following months to enforce, with decreasing hostility, needed limitations on her child.

Families of Juvenile Adolescents

Juvenile functioning in adolescence is the term used to express the arrest in social and psychological development of the intimidated youth. Their neurotic symptoms and various physical symptoms such as gastrointestinal reactions make them familiar objects of study to child guidance clinics and pediatricians alike. Our treatment methods with these youths and their parents resemble usual child guidance methods except again for the more prominent role given the father in therapy.

Fathers. Fathers of families with juvenile adolescents tended to make explicit their dissatisfaction with the mothering attentions of their wives toward the children. They behaved as though the team might help in alleviating the problem. The team responded by shifting the focus from the wife and the implied insult to her by calling attention to the usefulness of symptoms presented by the children. The symptoms appeared to be ways of avoiding the excessive expectations of aggressive capability that the fathers unwittingly attached to becoming adult.

In individual sessions these men needed immediate understanding attention to their problem with fear. This fear existed in many forms and was manifested as intolerance for any show of weakness in others, particularly in their own family members. The therapist acknowledged that this fear seemed to call for a pretense of strength in the form of an aggressive façade. He also showed that such a façade had led to much misunderstanding and failure to recognize the father's valid concern with tenderness which was masked by his fear of it. This approach indicates the therapists' view that the kindlier attributes are the ones suppressed.

The compulsive-aggressive ways of these men in relation to passive-aggressive techniques of their wives had forced them into situations of tyranny from which they were unable to abdicate. The team's approach to this situation was often to indicate to husbands that their efforts at hiding the presumed social or sexual impotence—a basic sense of inadequacy for which the aggressiveness compensated—may have precluded the possibility of allowing people any real chance to appreciate them.

The importance of these observations in relation to the adolescent's problem appeared in the team-parents conferences on the first day when the pattern of the child's way of recoiling from competition was presented. In a way that confirmed the team's stress on the importance of the father role, the therapists showed the child to be engaged in a search for strong figures to serve and with which to identify, by noting, for example, his allegiance to a neighborhood bully. The father of the intimidated child was no stranger

to such fears. He easily understood that it had become impossible for the child to think of himself as able to become a man in the pattern of such a forbidding image as the father had presented. A useful therapeutic strategy here was to show the possible rewards to the parent's self-esteem by allowing his child to transfer allegiance to him and thereby to become the adolescent's ideal.

The second morning often found the husband trying very hard to have the team appreciate the early life difficulties that made his problem with self-confidence and false pride difficult to change.

In tears Mr. Corbin insisted that the therapist could not understand the pressure from the unshakable feeling that his two parents were figuratively sitting on either shoulder—a mother who continually demanded he strive for achievement, and a father who recurrently raised the question, "Is that the best you can do?" Everyone seemed to want something from him; even the team, he felt, wanted emotional response from him that he felt would be inadequate if expressed. While paranoid in form, his attitude was the more labile one associated with fear of exposure. His great pretense of orderliness and morality was not that of a well-functioning obsessional character, but it was a thin façade by which he tried to keep inner chaos under control. He could allow himself no friends, but he was easily tempted to give promises beyond his ability to fulfill. He really assumed the intentions of others to be friendly but feared they would find him wanting. Actually, he demonstrated much ingenuity in being an effective provider. He was, however, reluctant to return to the clinic because he had not delivered as promised. The appreciation of the problem by the rest of his family and his own desire for relief from pressure led to substantial diminution in his symptoms and freedom from symptoms for the rest of the family in the course of 18 months.

It is interesting that, months later, when the boy had a slight accident while driving, Mr. Corbin recognized that his son was inclined to blame himself excessively and took steps to relieve this by insisting that the boy had done well but that he, the father, had not kept up proper maintenance on the brakes.

As tyrants who expressed themselves in terms of excessive criticism of mothering functions, these fathers had been too remote, too ambiguous about masculinity, and too uncertain of their own masculinity. Fear of exposure of fraudulence had prevented their

letting their sons get to know them. Hence they were clearly forbidding but shadowy as objects of identification. The team's certainty of their worth to their children and wives served as much-needed affirmation of masculinity, like a long-delayed puberty rite.

Mothers. Mothers of juvenile youth typically needed acceptance from the woman member of the team. These women seemed to "fence" ably with words, particularly with the male members of the team. It appeared that they enjoyed the competition, and in doing so betrayed their contempt for the aggressive façade of their husbands whose bluster dissolved in anger or prohibition of discussion when challenged. Recognition from the male therapist did not bring relief to the women but led to more resistive attitudes. They felt the male interest to be only a response to compulsive, albeit pleasing and provocative, behavior, the necessity for which was a part of the very problem by which these women felt enslaved.

Pretty and cute Mrs. Corbin seemed cheerful and vivacious throughout the team-family conference, in contrast to her husband who seemed to become increasingly disabled by his anger as he told of how poorly she had carried out his instructions concerning the children in his not infrequent absences. She maintained this gaiety through an individual session with the psychiatrist, during which she seemed to try to prove that she was a nice little girl who had tried hard but was not understood or appreciated by her husband. The preoccupation of the parents with peripheral details dominated the initial interviews. Mrs. Corbin tended to exploit the situation by exposing their favorite arguments. (Does one wear pajamas or underwear to bed?)

With the social worker, however, Mrs. Corbin was concerned with her repeated failures. This marriage, a previous marriage, and everything she had done was under her own mother's supervision. The task was to help her understand that she endowed her husband with her mother's disapproving qualities, while doing a very creditable job, under the circumstances, of being a mother not only to her children but to a considerable extent to her husband. Reassured of her womanhood and capabilities, she was able to plan with the team a much less scattered way of organizing her efforts at home.

In contrast, Mrs. Antanias was not quickly enough perceived by the team as presenting such a problem. There had been no formal intake

visit. By having the woman team member see her after the team-family conference, we put the social worker in the position of having to elicit the history of a discouraged attitude at a time when the mother had considerable resistance to revealing herself. Sensing that she could only present herself as an obstacle to change, Mrs. Antanias became increasingly resistive. Another mistake was then to expose her to a series of male therapists with whom she tended to reinforce her feeling of annoyance with the men in her life. Use of MIT at intake as a tool for early diagnosis and for planning therapy appropriate to the type of family has reduced such inappropriate management.

By the end of the first day these wives were inclined to view with alarm the extent to which they, like their children, had been intimidated not by husband's strength but by his intolerance which covered over his inadequacies. In half these cases this insight was a prelude to considerable work. Because of the readiness and need for this work, follow-up visits with these families were more frequent in the first six months of MIT. It appeared that MIT, by its access to the husband, was able to help him accept his wife's new-found sense of freedom. This tended to minimize the wife's having to act out by separation or divorce her new insight into the way her life had been limited by cooperation with her husband's limitations. Martin and Bird [10] have shown similar advantages and other advantages in simultaneous treatment of marriage partners by separate therapists who discuss their work.

On the second day the mother was usually able to get somewhat beyond her irritation with the way she had been suppressed. She was then able to study the way her efforts had contributed to keeping her husband in an aggressive role. This movement, usual to psychotherapy in general, is away from complaints and blame placing and toward the understanding of each person's contribution to the difficulty. Generally, the mother expected to be censured by the therapist for her competitive and passive-aggressive ways. What she did not expect was the focus on subtle ways in which she had gained her family's cooperation with patterns designed to protect and perpetuate her husband's feeling of inferiority. This is illustrated by Mrs. Kidder's attitude about her work.

indicated to the husband that he had a more important role to play in his family than the pompous one that had been assigned him.

These men were regularly surprised that their apparently self-sufficient wives, for want of more direct affirmation of their worth from their husbands, were excessively at the mercy of public opinion. Rarely could the wives indicate that the real reason for their wanting to appear in the "right" place with their husbands was to appear loved. The wives were quite shy about expressing their humiliation, which was evident, however, in their expressed attitude that they could feel respected only for evidence of good works. To avoid exposing their neediness they made all their demands in terms of what would be good for husband or children.

On several occasions the team observed that the mother's difficulty in letting her husband know of the importance of his approval was mirrored by the Cordelia-like role of their adolescent daughter. Like King Lear's troubled daughter, the girl would go to any lengths to avoid expressing affection to her father, whom she loved. The daughter's dilemma, like Cordelia's, was frequently complicated by its contrast with the attitude of siblings and relatives who appeared to the girl to fawn successfully on Father for approval. This example from literature was used with families of professional men such as lawyers.

In the session with the father immediately following the opening team-family conference, attention was turned to the impersonal quality of family life. The husband was invited to consider that his wife, possibly out of excessive guilt over previous failures, had served him too well—to the point that he had become ineffective in his own home and excessive in his activities outside the home.

In overlapping sessions the therapist who had seen the son or daughter was usually in a position to show the father that his child was very much identified with him.

Rocky Cramer, who had distinguished himself in school athletics, politics, and journalism, felt under excessive pressure to establish his own area of achievement. He was continually being urged by the family

to participate in athletics to satisfy the interest in athletics of his father, a member of the school board. The boy in rebellion seemed inclined to drop athletics participation at this school or to enter another school. The therapist noted identification with the father in the way the lad made the goals of the institution his goals as expressed through his work on the school paper and by class and team leadership. The overlapping therapist indicated to the father that his help was needed to deal with the disparagement from the mother, who stressed the view that other children at school felt her children's successes were due to teachers' desire to please the school board member.

The unconventional artist, Mr. Glamis, seemed to have similar difficulty in recognizing that the ritualistic incense burning and other beatnik behavior of his son, instead of representing rejection of father's influence, emulated it. Like his father, Scott had made a protégé of a more neurotic nonconformist, to whom he seemed to accord great deference. The father's way of detaching feelings from facts was shown to be reflected in a division of labor between his sons. Scott generally expressed feelings without facts, and his younger brother, with a pseudoscientific attitude, expressed facts without feelings.

The afternoon of the first day with the fathers of these rebellious youths involved quite regularly an exploration of the way in which they had become isolated into positions of only apparent leadership, and a study of their hostility over not having an effective part in the family plans. The husbands experienced mixed feelings of shame and of importance as they realized that their influence could relieve their wives from excesses of misplaced efforts. In the several families presenting daughters as nominal patients, the mothers had joined their daughters in excessive dedication to making each other uneasy. The mothers of the male nominal patients occasionally expressed a contrasting dedication. For example, Mrs. Cramer could not see what Rocky's girl friend had that she hadn't more of. This misplaced intensity of emotion was discussed in afternoon team-parent conferences of the first day. Shyness gave way to frankness and considerable relief of anxiety as the several approaches converged to make it obvious that the mother really wanted this dedicated attention from her husband. It was often not until the second day that the husband, somewhat freed from

the feeling that he ought to dedicate his efforts more to his children, was able to show that his wife might count on him for a more real basis for self-respect. When the child could see that Mother was first with Father, he was freed to earn and enjoy the respect of both his parents. Such improvement had occurred when at follow-up it was apparent to the team that Mr. Norton was able to accept in good humor considerable coaching from his wife. He had in fact taken over the management of the family's finances. The daughter was able to abandon her futile dedication to her mother's discomfort and to show open and uncomplicated effort to win her father's respect and approval.

Mothers. The mothers of these youths were quite concerned with matters of social status. The content of the initial team-family conference was slow to get around to the really sensitive matters associated with the referral. The mother typically expressed an attitude of superficial loyalty and deference to her husband's chosen career. This was presented as though to explain the family problem and to imply that this also was for her a kind of "cross to bear." This attitude of sponsorship of her husband was as true for Mrs. Tague, a schoolteacher whose husband worked 12 hours a day as a truck dispatcher, as for a prominent doctor's wife. Both saw the husband's long hours as a steppingstone to advancement which they seemed most active in encouraging. Mrs. Glamis, another schoolteacher, seemed to dedicate her life to urging her improvident husband, who worked only part time at his chosen profession, to realize his dream of becoming a full-time artist. Mrs. Beal's way of expressing this pattern was in her ability to extract promises from her physically handicapped husband about what he might be able to provide. He was rarely able to keep these promises within the time expected despite over-all increasing financial success. In a similar way these women seemed to accept the fact of relatives as active participants in the family life.

The team generally responded with a puzzled attitude, stating that they were not yet able to understand how the nominal patient

was afflicted with these family problems. This query led the mother to show that she felt betrayed and exposed to the community by the adolescent's acting out. The team pointed out that the conditions leading to these problems had rarely been discussed at home and seemed to have been kept obscure in this opening conference. When the nominal patient was a son, the mother was able to show a real feeling of regret about the loss of a once smoother relationship with him. When the patient was a daughter, there was the hurt reaction to what appeared to be the daughter's dedication to humiliating her. This reaction was in marked contrast to the family situation of the six schizophrenic patients and that of the autocrats, where the parent could not deal with the child as though he had that much significance in his own right.

In individual sessions that followed, considerable time was required to deal with the mother's resentment and feelings of humiliation, so that in half the cases the social worker who had seen her reported at noon conference that little progress appeared to have been made.

That there was progress, however, was indicated by the fact that in the first conference in the afternoon, almost always with a psychiatrist in these cases, there was an intensive outpouring of early life history comparable in depth to the conferences on the second morning with mothers of the more childish adolescents. Each of these mothers told of having entered the present marriage in a situation of disadvantage. Through her tears Mrs. Byron told how the men congratulated *her* at the wedding on being able to win such a fine husband. She felt this as a continued reminder of the community's displeasure with her previous marriage.

The therapist easily detected that these men, who seemed to abound in goodness and special talent according to their wives' public description, were really regarded by them as fragile and as objects of contempt. Resistance to revealing this attitude was supported by a tacit agreement of the marriage partners not to reveal vulnerability on either side. Therapy was directed at casting doubt

on whether the presumed weakness represented real handicaps. The next step was to encourage reappraisal of the spouse to consider whether he was really inflexible or whether his wife was not perpetuating a myth about him by serving him excessively and as a result only allowing him a limited sphere of operation in the home. The doctor's Sunday afternoon with his relatives was always attended without question by the family. It was mother who alleged that the father would want it that way. Father privately wondered if the children would not rather go to the beach.

On overlapping interviews we regularly found that the mother felt she began to lose control of her child when the father, using his protected and privileged position, began to treat wife and son or daughter as equal petitioners. This loss had been painfully experienced as a show of disrespect for her in the child's presence. The discussion frequently showed the disrespect to be an aspect of father's insensitivity due to his remoteness and in part due to his inability to take a clear stand on anything.

Mothers of acting-out daughters had little difficulty in realizing that the father's position had been held so sacred that the mother had become obscure as a person with whom to identify. The fear the rebellious daughter showed of the father and her defiance of her mother, together with the parents' excessive concern with the possibility of the daughter's sexual acting out, were indicated by the team to be reflections of the parents' own lack of comfort in intimate situations.

Family. In team-parent conferences the parents became aware that the antidote to the child's rebellious way of causing restrictions to be placed on him was for both parents to become more explicit and firm authorities, each in his own right. When the father really exercised authority on behalf of his wife, the daughter was less plagued by her mixed wishes and fear of his attack. She became less afraid of her own ability to qualify for the freedoms she seemed to be demanding. Final conferences then tended to deal with practicalities of scheduling and making possible many of the privileges the youth demanded.

THE ROLE OF THE YOUTH IN TREATMENT

Generally the amount of time in MIT devoted to the youth differs very little among the types of adolescent maladjustment. After initial team-family conferences, the adolescent was seen individually each morning by different team members; other team members saw him later in these sessions by the overlapping procedure. His first afternoon was usually spent in diagnostic psychological testing. Where testing had already been completed, often a community representative or other person added to the basic team interviewed the youth in that first afternoon. On the second morning the individual session with the nominal patient was sometimes followed by a joint session with a parent. On several occasions, as in the Jones case, the team members withdrew from the room, leaving the youth and parent to continue their discussion alone. The first part of the second afternoon with more exploited patients was spent in conference with one or two team members discussing an anticipated change in the youth's role in relation to the rest of the family. Frequently he was then excused until the beginning of the final team-family conference, perhaps to ponder the possibility that the parent whom he had long specialized in manipulating might no longer be so exclusively at his disposal; but neither might the parent be so oppressively attentive ("on his back").

The juvenile adolescent more usually was seen in a combination of play and individual therapy techniques through the second afternoon until a later point in the final team-family conference. Dart-throwing sessions frequently led to useful observation and discussions of the adolescent's attitude toward competition.

The adolescent manifesting preadolescent functioning, in contrast with the other types, was more frequently brought by his interviewer to an overlapping session with both parents.

In all but one case of each type, the youth perceived our intention to have the presenting complaint make sense to the family as a logical way of dealing with them. This perception by the youth

seemed to reduce his acting-out tendencies during therapy. The object of initial individual session with the youth was to help him see that he was being exploited quite as much as he was controlling others. The therapist expressed concern that he was paying too big a price by self-defeating mechanisms and in the loss of contact with age-mates. The attempts the youngster made to influence others through threats to absent or harm himself were interpreted by the team as evidence of depression and also of his need to be important to others. The material so developed was usually presented by team members to the parents and was confirmed in team-family conferences. Often the youth's inability to accept relinquishment of control, fantasied or otherwise, led him to threaten not to participate in the second day. We always took this maneuver seriously. On such occasions one of the team members separately made a special appointment to see him the next morning. We did not seek a final resolution of the problem as it appeared to the adolescent during the two days of team and family work. When the adolescent maintained a resistive attitude, the team respected his need for the defense and simply kept him informed as to the changing balance of forces in the family, fully expecting that the youth would later test that out for himself.

In the Jones case a preliminary sampling was made by the youth of the changing family pattern in a brief conference between the father and son before lunch on the second day. It led to the youth's explicit support of the anticipated changed relationship between parents. Even so, it was not a meaningful change to the youth until he had lived with it and tested it again on New York's Eve, six weeks later.

When working with the childish youth we were dealing with youngsters who, while not "adult-value-centered," had in common with the team the asset of being specialized in dealing with immature adults. For that reason we were able to discuss directly with them ways of decreasing parental dependence on them. The fact that they had been "calling the shots" at home, and had been excessively the center of parental attention, was also an indication for periods of therapeutically planned neglect during the two days

of work. It was usual for the team to leave the childish youth in the waiting room during some of the later conferences on the second day as evidence of the attitude that the youth had already been excessively meddlesome in adult matters and was being freed to go on about his business of growing up. The pattern of working with the childish youth was that illustrated in the Jones case presented in Chap. 2 and discussed in Chap. 3.

With juvenile adolescents we tended to work with the youngsters' problems of fears and anxiety in a manner typical of child therapy generally. Often these anxieties were centered around dealing with school situations. The presence of the nominal patient at team-family conferences, like the presence of siblings of the other types, was intended to help the youth have contact with the kind of change that might be taking place in the family. The adolescents said little in the discussion; instead their symptoms spoke loudly for them. Team members reported their understanding of the symptoms to team-parent conferences more often than they actually brought these youngsters to overlapping conferences. The adult-value-centeredness of these overserious adolescents did make it possible to work with them directly on problems of their own anxieties and to interpret to them the work with their parents. In the manner of adult therapy, this included understanding the father's temper and his difficulty in providing a clear model of manhood. The team placed emphasis on the youth's failure to notice his own provocative ways and his failure to realize that his father's behavior stemmed from a lack of self-importance. Therapy was thus directed at the feeling of not being important to others. The work with Bronco Critchlow is illustrative of the movement with such neurotic children in MIT.

This forlorn-looking lad was described in Chap. 4 in terms of his symptom of pulling out patches of hair. The boy described persistent attention of a group of bullies who teased him about his appearance, made him stand on the school bus, and burned him with cigarettes. His father, intolerant of weakness, regularly recommended that this anxious, fearful lad hit back. He particularly nagged him about forget-

fulness in packing the car for fishing trips. In individual sessions the boy was helped to see how he unwittingly fascinated the bullies and other people who fear weakness. He realized that this experience of being a target for others was only an expression of his own need for popularity. He had overlooked this possibility in not realizing the impact his provocative ways were having on his attackers and his father. In group situations he heard how mother's symptom of obesity similarly served both as an excuse for not associating with others and as a way of actually repelling others. In subsequent individual sessions the therapist helped the youth foresee the possibility of better ego strength from identification with Father. He identified with Father in subsequent group sessions as he became angry at his mother's failure to see that what made Dad angry was her tendency to plague him with her many ill-founded fears of dealing with the outside world. The boy began to borrow courage from his father and to explore his new neighborhood. Like his father, he turned his attention to coaching a friend—a chum who never seemed able to assemble his fishing gear properly—in the ability to plan ahead.

The fear of initiative in the boys seemed to have been related to fear of retaliation by their fathers, and guilt was related to closeness with the mothers. Subjectively the youngsters felt the associated rejection by their fathers as indicating something "sissified" about themselves and as part of the reason they could not be accepted by their peers. Since most of them were about 13 years old, the possibility of identification with the parent of the same sex was explored. The team contributed to the youngster's understanding by making a constructive reappraisal of the parent, showing that the parent responded in very human ways that, like the child's symptom, were understandable.

In the cases of preadolescent functioning in adolescence, we were dealing with youngsters who were demanding privileges of adulthood, the responsibility for which they had clearly shown themselves unwilling to accept. These youths won our respect by their special kind of integrity. They stuck to the value system of their group and their position against family values. Their misbehavior seemed sometimes almost deliberately calculated to require

parental disapproval, or firmer limits on their activities, or clearer or more consistent discipline.

For example, one girl left her diary, which described torrid petting sessions, where her mother could find it. Another left in her school desk pornographic notes regularly collected by the strict but fascinated male teacher. "Running away from home" was common among both boys and girls in this group, but the act of running seemed designed to guarantee their being sought and found, and it frequently terminated in a voluntary return within 48 or even 24 hours. The Glamis boy returned before reaching his proposed destination in another city (where he was assured of friends who were sympathetic with his practice of yoga exercises with incense) in order to keep an appointment with his probation officer.

The adolescents were not particularly interested in discussion of what would be best for the family. Several of the young women seemed surprisingly dedicated to making their mothers uncomfortable. Others showed their interest in their families through a competitive nagging relationship with a younger sibling whose freedom they seemed to resent.

Therapeutic work was under way when the team members showed recognition of the youth's troubled quest for certainty. The therapeutic approach involved expressing appreciation of the respect most of the rebels had felt for someone in official capacity who had intervened to set limits. Just as these adolescents did not want to be treated as peers by parents, they did not want those they would respect to be converted to adolescence. It was important for the team members to respect their loyalty to particular adult-opposed group standards without the therapist "crossing the line" to indicate approval of those standards.

When a therapist, the resident in psychiatry who had worked with Billie Beal in the hospital, sided with her to the extent of allowing himself to be used as a mediator, carrying messages and arguments on the patient's behalf to her mother, the resident lost the patient's re-

spect and she felt unsafe in relation to him. This had a background of occasions when various teachers and persons in authority, whom she had tried to manipulate, seemed to succumb to her charm in a way that led to peerlike relationships which by her account seemed more like courtship than professional behavior. More importantly for present purposes, this was frightening her.

After establishing with the youth that his efforts tended to deny to him the very privileges he seemed to be demanding, the team members working with the rebel patient typically addressed their work to showing the youth that he should indeed merit such privileges. The privileges demanded tended to be but exaggerated versions of the responsibilities appropriate to his age, such as the operation of an automobile or the setting of his own time limits on dates. Frank discussion of the rebel's doubts of his ability to handle these responsibilities often led to alleviation of underlying doubts about approaching manhood or womanhood and relief of the fear that should others really get to know him, they too would find him inadequate to handle responsibility. This fear was usually the reason given for their efforts to diffuse their individual identity into group identity. We discussed the fear of the unknown—both that of the parents and that of the youth—and tried to suggest ways that each could become clearer in his identity to family and community. In this way we helped these youngsters turn to practical thoughts and plans for activities leading to emancipation and better capacity for real interpersonal intimacy and identity.

The final conferences with these adolescents and their families were the least dramatic. They seemed like quiet discussions involving the parents as consultants.

CONVERGENCE

Convergence refers to the way in which the reports shared in overlapping joint interviews and family group situations progressively yielded a consistent dynamic theme. In the two-day period each patient pointed up his patterns of relating to an individual therapist. On hearing these patterns presented in the context of

data developed with other family members, each patient was able to participate in relating the themes to a corrective course of action.

The validation of the existence of unrewarding patterns and the awareness of behavior that signaled repetition of these recurring interpersonal patterns were cumulatively reinforced in MIT as the phenomenon of convergence occurred. This jointly witnessed convergence appeared to keep the effects of MIT active as a part of self-rehabilitating forces during the months after the family left the clinic. These are the patterns by which the family members become predictable to each other. The fact that the personalities of the family members were various meant that what was too disturbing for one parent to notice could more easily be remembered by another. This made it more possible for the family to identify the signal of the repetition of such patterns.

In describing examples, perhaps too much stress has been placed on events leading to change. Certainly one finds in the two-day sessions less of the working through to insight characteristic of other psychotherapies. Instead of the re-educative process, MIT is an attempt to reinstitute natural processes. Change resulting from MIT occurs as growth changes occur. This is not so much by the detailed understanding of inner conflicts or obsolete goals as by making them less important by opening up a view to the future. This is a movement from a closed system which maintains the *status quo* by collusion and balance-of-power strategy to an open system which permits attention to the developmental tasks appropriate to current living.

FOLLOW-UP

The clinical evaluation at follow-up is described in terms of the *approach to the initial objective* and the therapeutic task at follow-up usual for each family syndrome.

The Six Schizophrenics and Their Families at Follow-up

The approach to the initial objective with the families of infantile adolescents involved first some work on the part of the over-

involved parent (in these cases, the mother) to free herself from guilt feelings associated with attending the child less. This was aided in each case by a temporary increase in father's participation with the youth.

Harold Mullins, as described in Chap. 4, worked with his father in the project of building a home from the abandoned school, and tried to appear interested in hunting, fishing, and "glad hand" socializing.

Matt's father, like Bonnie Birge's father, was more the one who urged infantilizing the child. When the mothers found employment outside the home, these men temporarily indulged themselves by taking over the hour-by-hour supervision of the child on the farm until both parents gained enough perspective to be able to collaborate in developing a plan for the child's education.

Forester, Milton, and Zilcheck, with the guidance of probation department, church, and school counselors, respectively, took a more active part in trying to improve their sons' hobbies and studies.

The aim of finding a more adult object of self-expression was achieved by four of the mothers, who developed satisfying vocations. Another sought individual psychotherapy, while Matt's mother made the separation by sending her son to visit with relatives and learn a trade in another state. It was when these mothers achieved some freedom from a mutually consuming relationship with the nominal patient and an outside basis for self-regard in their work that the husbands' position began to change. They were all highly schizoid men. The result of mother's initial change from preoccupation to occupation was in each case that she was less at the mercy of her husband's psychopathological condition.

In the Birge case, the mother took a position selling and demonstrating health equipment in their county. Six months later the mother was a happy, vigorous woman who said she was able to give Bonnie better help because she was with her less. This schizophrenic daughter, who had previously not been able to let her mother out of sight, had been able to accept farm work with her father and supervision by his relatives. The father, examined psychiatrically and psychologically at this

point, appeared to have more free-floating anxiety and preoccupation with impotence. His pathological condition, while more obvious, affected others less. In the next year his wife was able to become more appreciative of his efforts and more understanding of the hampering influence of his own family's domination. Evidence for the validity of this was provided by the uncomplicated nature of the mourning process through which she was progressing a year later, shortly after Mr. Birge was killed in an accident. The daughter had worked occasionally, but resisted participation in a state vocational rehabilitation program. On the occasion of the 18-month visit Bonnie was a gracious hostess to the team in her mother's home.

The therapeutic work at follow-up with the families presenting infantile functioning in adolescence, then, was that of helping the mothering one to accept less dedication of self to the child. The team worked toward enabling the parents to understand that the immediate changes of relief from the intensity of the relationship with the sick child did not necessarily mean that the child would very soon be on a competitive basis with age-mates. Often it meant helping to recognize that some of the increased ineffectiveness of the husband was a necessary readjustment—as after unemployment—from having been pathologically overoccupied.

The Autocrats and Their Families at Follow-up

The therapeutic task with the families of the autocrats at follow-up was more a matter of supporting the father's new, and sometimes awkward, efforts to exercise more leadership in family matters. The wives were characteristically able to enjoy a more passive position, but had achieved only a modicum of self-esteem. They needed help to appreciate the husband's leadership as renewed interest in themselves. Many of them reported with pride on their husbands, but still had a need to state in terms of a progress report on two "children," the husband and the nominal patient. The husband's role in helping his wife with her self-esteem was frequently the therapeutic focus.

Achievement of the initial objective in the families of the childish adolescents was marked by improvement in communication

and enjoyment of socializing between father and mother. In 10 of the 15 families where this occurred it happened in the first few months with what appeared to be lasting favorable consequences for the rest of the family. In each such case the nominal patient responded with a vigorous test of the new relationship. The parents successfully passed the test by mobilizing in a mutually supportive way that proved to be convincing demonstration that a new and healthier balance existed in the family.

Carl McLean, age 14, was referred by his probation officer for a long list of petty solitary vandalism, usually in churches or public buildings. On investigation by the probation officer his relation with school, home, and authority seemed so strange that court hearing was set aside for psychiatric investigation. The family had not known of his nocturnal escapades. The teacher complained of his fecal incontinence. At the clinic Mr. McLean at first seemed to be cool and detached, but became tearful and depressed as he discussed his lack of influence at home. His wife was incoherent in her verbalization, hostile, and tense—literally wringing her hands. The boy described his antisocial activities without anxiety but with occasional inappropriate laughter. In a manner typifying his inability to submit to control, he justified his soiling on the grounds that the teacher had interfered with his "right" to go to the bathroom at times of his own choosing. The course of MIT was not remarkably different from that described with the Jones family in Chap. 3.

The family were seen again about five months later at their own request and at the request of the probation officer. They had just handled a new crisis rather well. For some time Mr. McLean had become more and more influential in the daily life of the family and was clearly becoming Carl's preferred object of identification. Mrs. McLean complained that during this period, that seemed to encourage her husband, she herself had the sad feeling that Carl was becoming less and less her son. She recalled earlier years when he slept with her while her husband worked nights. Thus, depression appeared to pass from father to mother. Her reminiscence seemed to be a part of working it through. As Mr. McLean was able to show leadership in handling the current crisis, his wife became more confident in her dealing with Carl's techniques for getting his own way. The episode that led to their return to the clinic was clearly a product of Carl's depressive reaction to the loss of his old power to command. It was not solitary vandalism. He

and another discouraged lad, the son of alcoholic parents, resolved to break into a home in daylight, steal enough funds to leave, and find their fortunes in another state. They were unsuccessful and their efforts were reported to the police by the neighbors. Carl's father took the initiative in arranging restitution and both parents responded to the situation with considerable sympathy for Carl as well as for his friend. Mr. McLean sought out the juvenile court judge who had previously suspended action. He gave the judge the changed picture of family life, and the boy's favorable response to sympathetic but firm handling. The case was returned to the probation officer who sought the clinic's opinion. The boy's acceptance of the way the crisis was handled marked the end of his depression. The family rehabilitation was affirmed in several ways at 18-month follow-up. Mr. and Mrs. McLean seemed relaxed and comfortable with each other and with the team. All family members evidenced pride and affection for the new baby, and the three children showed no evidence of jealousy or insecurity with the advent of another child. This was in marked contrast to earlier situations. Carl had reacted with anxiety and regression when the second child was born, and both Carl and his brother were similarly affected by the advent of the third child, a girl. The change seemed to demonstrate a clear movement in the family from an economy of scarcity of love to a situation of abundance, with each child feeling secure about his own place in the family and in the world. Carl's progress was marked by academic, athletic, and social recognition at school, and the disappearance of the behavior in the initial complaint picture.

In two families (Parr and Phipps) from broken homes, analogous processes were effective where conflict decreased with improved communication in the relationship between the widowed mother and her oldest daughter in one case, and between the grandparents and their married daughter in the other.

The Intimidated Adolescents and Their Families at Follow-up

All 14 families presenting juvenile functioning in an adolescent have shown satisfactory progress. Movement has not been remarkably different from that usually found in the family of the neurotic child, where the marriage partners and the child are treated with procedures usual to the child guidance clinic. Perhaps the signifi-

cant contribution of MIT here was in helping one spouse accept change in the other. While the change in general was from a competitive to a collaborative relationship between the marriage partners, the first stages of the movement involved strong expression by the wife of a desire for freedom from intimidation by the excesses of fear-driven intolerance of the husband. After several months these families seemed to take an interest in some sort of family project. This contrasts with the other types, possibly because the nominal patient was on the average younger. The patient's problem, therefore, was not usually how to emancipate but how to live with his family. With these families, where the neurotic interaction in the marriage frequently was a part of the initial complaint, follow-up therapeutic work involved further study of the content of distorted attitudes which had plagued the parents' perception of each other and which had been transmitted as excessive expectations to their children. This stands in some contrast to the work at follow-up with the other types, in which the team concerned itself more with the study of changes in the family to correct situations that had resulted in exploitation or neglect of a child.

The Rebels and Their Families at Follow-up

Rehabilitation of these families, which had already demonstrated sufficient health to get their youth past some significant developmental hurdles, involved more varied goals than did the work with the types discussed earlier. Work with these families was more difficult. Perhaps the resourcefulness of the family team more nearly equaled that of the treatment team.

Therapeutic work at follow-up with these families, where rebellion of the youth had frequently become redirected toward more realistic efforts at emancipation, often had to do with helping the family accept and feel pride rather than insult and depression when their youngsters began to have constructive relationships with peers and adults outside the home. Occasionally, these parents were in-

clined to respond destructively to new and constructive self-expression in their youth.

When John Bill Byron's father talked with his son's first-sergeant, he was surprised to find that in one month of military service his 17-year-old son had become regarded as well disciplined and an apt learner. The boy's employer on the summer construction job which he held a few months before entering service also spoke highly of him. The parents felt bitter and wrote their son that they regretted that their efforts had never been rewarded by mature behavior. In his reply John Bill tried to thank them for a good background. He told of his plans to visit home, but seemed to his parents to stress the idea that it would be to see his girl friend. The mother revealed her pride in showing the letter to the team at follow-up. But her reply had been to tell her son that the girl back home was running around with some of his old rivals.

In a series of letters to the team preceding the follow-up visit, Mrs. Byron had affirmed her understanding that the family difficulty centered around her feeling that no matter what disrespect her son showed her, her husband would suggest that she provoked it. During the two-day MIT work in Galveston six months before, this statement of the problem had involved the couple in noticing that what they were to get out of life they had wanted to get from their son rather than from their own growth experiences. At six months follow-up the team addressed itself to helping them appreciate the favorable life experiences that had to be behind their son's good adjustment.

It seemed difficult for the parents of the rebels to appreciate the ways in which they had done well in preparing their youth for life.

In each of the 15 cases where there was therapeutic movement, the strength of parental authority became a more visible reality to the adolescent, and identification with the parent of the same sex became constructive.

Mr. Pike terminated his wife's employment and access to an automobile. While she complained to the follow-up team about his restrictions on her living, she had fallen in line to the extent that the problem of infidelity was no longer present. Their delinquent son had become respectful of his father. The boy took a job that involved equipment maintenance and indicated pride in his work; only a few times had he had to seek the advice of his father, whom he now obviously

regarded as a superior mechanic. The visiting therapist had some work to do regarding the son's way of showing disrespect for his mother. However, it was interesting to hear the son advise his mother that, if she wanted to use the family automobile, continuing in the pattern that promoted Mr. Pike's difficulty in trusting her would not help. While his attitude lacked respect, it does illustrate the way in which one family member recalls what another may have suppressed after psychotherapy.

The therapeutic task at follow-up with the rebels and their families was that of helping the family recognize that the changes in behavior of their youth, while often not so comforting as in other families, tended to be in the direction of showing increased ability to handle the responsibilities that go with young adulthood. It was also the team's task to help these parents, who had been so occupied with their children's rebellion, to assess the benefits to themselves of their own mature ways of dealing with each other and their children, rather than continuing to look toward the achievements of their offspring for their own satisfaction in living.

SUMMARY

This has been a chapter on the various psychotherapeutic operations included in MIT. It has been shown that while the procedures of scheduling are new, the operations involved are those familiar to well-trained therapists. New developments in psychoanalytic and sociological theory have made it possible to focus the work on the release of growth processes, which are often inhibited by the collusion in families to maintain even a sick *status quo* when the family unit is threatened. These new discoveries were aided by the observation that tender feelings are more deeply repressed than hostile ones. Loss of resourcefulness results from the broken communication patterns that develop in the defensive situation. While the family continues to function on principles of homeostasis and complementarity of roles, intervention of a team appears useful in opening its pattern of closed defensive functioning.

Group phenomena peculiar to this therapy have been reported

and techniques imported from group therapy have been described. Concurrently a genetic approach to the understanding of the individual problems with maturing has been pursued, so that the identity and responsibility of the individual was also freed from the press of group identity.

The work with the father has been stressed, partly because other therapists have neglected his role. Moreover, our study of disturbed families has convinced us that the father contributes significantly to family disturbance, and that his role in family therapy can hardly be overemphasized. In our culture, the father usually has his self-esteem based in part on community functions outside the family's defensive system. In this one aspect, he is more like the team members than like his wife, who may depend almost entirely on the family for satisfactions in living, and whose self-esteem may be largely based on her own feelings of adequacy in the roles of wife and mother. The father, by his very remoteness from the intensity of interpersonal relationships within the family, is able to observe the interaction of other family members, and can be a reliable informant about behavior and interaction patterns between his wife and children. But he is often unaware that his remoteness, or less intense emotional involvement with wife and children, may contribute to the mutually exploitative patterns between them. In MIT, the therapeutic effort with the father is focused on the importance of his roles of husband and father, both as a constructive factor in the health and growth of his wife and children and as an affirmation of his own adequacy as a man.

That MIT is a comprehensive therapy is indicated by the demonstration in this chapter of four different paths it may take, appropriate to four different kinds of families.

In work with the families with an adolescent arrested at an infantile level, the initial situation was that of parents complaining bitterly about each other's shortcomings and presenting a child who responded to their leadership default by continuing to live out the privileged relationship of infancy. Initial therapeutic effort was to help the parents develop quite contrasting functions in

the home, which released the overinvolved parent to develop a basis for self-respect other than through mothering. Less than with the other types did the team seek a mutually supportive relationship as its initial objective. Later work often involved helping one parent in particular to accept guilty feelings about attending the child less, and to accept the slow pace of improvement.

The presenting situation of the family with the childish adolescent as nominal patient was that of a controlling child whose mother had become disenchanted by the hostile demanding of the child and whose father had become excluded by the intensity of that relationship. The team's initial effort was to gain the father's support of the mother in a relationship in which she could better affirm his manhood, and in which he could help her get the validation of her womanhood for which the child had heretofore been exploited. Later efforts had to do with the guidance of the occupationally displaced nominal patient into activities more appropriate to his age. These youngsters, used to manipulating adult emotions, often became quite cooperative with the team's effort to get the parents "off their backs."

With the families presenting juvenile functioning in adolescence, the presenting situation was that of parents highly competitive for acknowledgment of leadership and a child so intimidated by their aggression that he could only achieve significance through symptom formation. The team's initial efforts had to do with revealing to the family members within a family context the way in which they shared responsibility for keeping their unhappy pattern going. In individual sessions the history of one parent's problem with fear was studied. The other parent's exploitation of the aggressive façade that masked that fear instead of developing his own personal resources was also studied privately. The work with the child often had to do with helping him appreciate his own real importance to his parents. Later work with these families had more to do with developing shared projects in which they became collaborators.

The rebel and his family presented initially a more united front

to the team. The initial work was often to help get rid of the fraudulence of their social façade. The institution-like way of family life often had made the adolescent doubt that any important matters could be meaningfully discussed at home. It had led him to rebel against the possibility that he might be expected to handle adult responsibilities without any guidance except that the family had always behaved in a particular pattern. Individual work was directed toward helping the father, who had become but a figure-head, to appreciate his personal importance in helping the adolescent achieve a personal identity. Work with the mother was usually a matter of helping her find that in seeking significance through sponsoring her husband she had falsely presumed inferiority on her own part. Later therapeutic effort involved work with the adolescent and his parents on how to negotiate more meaningfully for the very responsibilities of which he had previously attempted to prove himself unworthy.

Thus, therapeutic movement in the series of 62 cases shows initial objectives which involve differing emphasis on work with the whole family as collaborators corresponding in amount roughly to the level of the developmental diagnosis. With the families of schizophrenic youth, work with each parent was quite different in that the objective was to have the father temporarily supplement the mothering functions. With the families of the childish youth, the work with both parents was more alike; its objective was to have the parents find strength from each other rather than from exploitation of the child. With the families of the juvenile youth, some analytical work was done with all members but there was more work in the neurotic interaction in the marriage. With the families showing preadolescent functioning in adolescence, there was as much work with the rebellious youth as with the adult on how to negotiate responsibly in an adult world.

CHAPTER 6

The Team

In previous chapters we have illustrated and described a method of psychotherapy and the types of patients who have been treated by it. We have related the method to theories of psychopathology and to the dynamics of mental health. But there are other important factors to be considered in evaluating a method of psychotherapy; for example, the attributes of the therapist, the skill with which the method is applied, and the possibility of training others to use it are several mentioned by Strupp [1].

This chapter considers the therapists both as individuals and as a team working with a family unit and its individual members. We shall also discuss here the function of MIT in training medical students and advanced students of psychotherapy, its use in supervising a clinic staff, the demands it makes on the therapists who use it, and the problems it poses for the clinic in which it is carried out.

First, let us consider "the therapist." In this work two aspects of the therapist are to be studied. "The therapist" for the sick family group is a team, a group which has some family-like processes that function in a relatively healthy way. "The therapists" for the individual family members who pose problems in their intimate relationships are the individual team members who meet with family members privately.

The team is a group that has developed the special ability to analyze openly some of its own processes in a way that teaches the family by example how to look at itself. Like individual psychotherapy, the team-family conferences are to some extent apprenticeship training in self-study. For example, the way in which the team deals with its own problems of individual responsibility, intimacy, and leadership both in team-family conferences and in individual sessions provides a model that may help the family develop similar ways of dealing with its problems.

Many adolescents fear individual responsibility and intimacy. If they are to be helped, it is important that the team set a useful model. For example, when it appeared to one team member that the discussion in the opening team-family conference of Rocky Cramer's dating was only forcing him to defend anything adults disapprove, that team member interrupted the discussion and asked to discuss the matter privately with Rocky. The therapist was able to point out to the group that there was a parallel situation at home. Just as the boy had to defend in that conference more actions than he had committed, he had been forced by the public debate at home into a relationship with his girl closer than that for which he was developmentally ready. The doctor's leadership in terminating group debate of the dating served as a model to the boy and his parents of adult respect for youthful relationships. Occasionally, however, the team continued to confront a family member as a group, when a demonstration of ability to take individual responsibility was needed. This occurred in the Jones case toward the end of the first session with Mr. Jones, when the parent was led to express doubt of the quality of his own family leadership in the presence of three doctors in a "bull session" atmosphere. When, on occasion, individual team members have avoided responsibility by diffusing it into the group, or avoided use of private sessions for discussion of intimate matters, they set a model not of maturity but of preadolescent functioning.

Recently, we observed that an inexperienced MIT team of trainees, who worked constructively with the parents of a family in

group and individual situations, saw the adolescent daughter only in group situations. This led to acute discouragement on her part. She became more and more fearful that her worries about sex were too terrible to take up with anyone. In this instance the senior psychiatrist working with the trainees corrected the situation by arranging individual sessions with the girl. This remedy also conveyed to the family by example something of what had been said in words about a need for more decisive leadership on the part of the head of the family.

TEAM-FAMILY AND MULTIPLE-THERAPIST SITUATIONS

Observing family members together provides an opportunity to evaluate interpersonal relationships within the family. Such advantages as these are responsible for the growing use in guidance clinics of group interviews during intake procedures and at times in continuing therapy [2]. Team-family conferences say to the family, both literally and symbolically, "This is a family affair."

Listening—with a Difference

Each member of the therapy team understands and hears a little differently what is said and left unsaid. When these differences of opinion are openly discussed in the family's presence, and do not lead to an impasse or to hurt feelings among team members, the family may learn how to have differences among its members. From the acceptability of competing suggestions the family observes that there may be several ways to diminish or resolve the family's difficulties. The team is more interested in having the family entertain the idea that there are solutions than in advancing any particular remedy.

In a number of multiple-therapist sessions, sessions in which two or three therapists met with one or more members of the family, the various therapists held differing opinions about such recurring problems as a weekly allowance, use of the family car, responsibility for dishwashing, lawn mowing, and other chores. Such differences

of opinion among team members usually concerned specific issues about the family present at the time, but occasionally referred to differences in over-all philosophy and attitude about child rearing. A sharp and dramatic difference of opinion among team members occurred in a family-team conference with the Jones family when two team members seemed to advocate that the father administer corporal punishment to Peter and two other team members opposed this.

MR. JONES: I let him out of it.

DR. SERRANO: Let him up, actually. What the kid has been doing was to insult Father in the open, and call him all kinds of names. . . .

DR. MACGREGOR: And really wishing that Father would. . . .

DR. SERRANO: Would beat him up.

DR. MACGREGOR: Would show him the limits beyond which he could not go.

DR. SERRANO: Yes. What he is asking for is a good beating.

MR. JONES: Well, I. . . . He almost got one.

MRS. RITCHIE: But at the last minute you backed down.

DR. MACGREGOR: [*Very slowly*] I can't recommend this. I don't think that this boy needs a beating.

CHAPLAIN: He needs something entirely different from that.

MRS. RITCHIE: Not now, maybe earlier.

MRS. JONES: Yeah! But years ago when he tried this, if I'd kept my mouth shut, we probably wouldn't have the problem we have now. Of course, I decided that he . . . it was time for Dad to take over. Well, it was a little late then, because Peter was just a little bit too big. If he had been doing it all along it would have been different.

This freedom to disagree was a living demonstration of differences of opinion without loss of mutual respect.

Protective Intervention

Patients in group therapy are especially attentive to the way the therapist treats the most vulnerable person in the group. When

the most vulnerable patient is treated gently, all the others feel safer with the therapist. This is also true of family therapy. We have found that a therapist's efforts to help "save face" for an adolescent, or anyone who had revealed more of himself than he intended, strengthened the confidence of the whole family in the team. Often the gentle correction of a trainee by a team member performed this function.

For example, this was shown by the way Dr. Serrano, without embarrassing the resident, restrained him from exciting Peter Jones's hostility toward his parents. Dr. Serrano did this by speaking on behalf of the parents and drawing evidence from the patient, showing the boy's realization that his mother's inability to let him have girl friends and his father's inaction were unwitting and uncomfortable for them. Thus, the senior doctor saved face for the resident, and without shaming the patient for his hostile outburst concerning his parents, increased the boy's feeling of collaboration with both doctors. The team's psychiatrist allowed this patient's identification with the team further expression by encouraging a joint consultation with Mrs. Jones, which the resident arranged.

The vulnerability from having exposed real feelings led to mounting tensions which were manifested by the defensiveness of the nominal patient, the misplaced hostility of the resident toward Peter's parents, the threatened exposure of the inadequacies of the father, and the imminent realignment against the mother. These tensions were reduced by the senior team member's corrective and interpretative comments, so that the final team-family conference was a therapeutic experience.

The multiple-therapist situation which permits expression of whatever any therapist considers useful has built-in controls. Interruptions are accepted from teammates and family on the ground that all are assumed to be working toward the same goal. When a patient's excessive intervention began to monopolize or delay the discussion, this effect of his behavior rather than the content of the discussion was analyzed. When this did not work, the monopolizing person was allowed an individual session. When the team-

family conferences ended and the participants moved into several simultaneous individual sessions, or sessions of two or three therapists with one or two family members, any team member was free to leave the session he was in and go to join another. This serial overlapping technique was illustrated in Chap. 5 with the effect that the whole group was brought up to date on an important new insight. Such cross monitoring (a term supplied by Gregory Bateson during a visit to the project) within the team permits supervision of the less experienced staff members. It also frees a less fully trained member to speak up. He knows that if he gets in a jam someone will bail him out. Cross monitoring frees therapists from the neutral position traditionally assumed in doing individual therapy, and allows the experienced therapist to involve himself deeply at times as a participant in the family interchanges—experiencing directly the collusions and cross currents of the family conflict while confident that a watchful teammate will provide perspective if necessary. It is helpful for a therapist to alert team members when he is going to allow himself more involvement. Before the chaplain came to Mr. Jones's defense in his first session alone with team members, Dr. MacGregor had said in the presence of the others, "Now watch me, I feel quite critical of Mr. Jones."

One of the uses of MIT is to help family members learn to be aware of and to discuss their mistakes with the rest of the family. Team members teach this by showing how they can be self-critical and accept corrections in the presence of others.

THE INDIVIDUAL SESSIONS

The value of regarding the entire family unit as the patient was repeatedly demonstrated as our study progressed. However, each member also needs to be regarded as an individual with problems and abilities that are relatively independent of the family—a need difficult to fulfill adequately in group sessions with all the other family members present. MIT, therefore, includes individual sessions in which problems of each family member are considered in private. The family member in this way discovers that the thera-

pist he has seen in group situations has the capacity for intimacy and can be trusted to help with the patient's difficulties in relating intimately. Appreciation and exploration of the problems of intimacy and isolation with such a person eliminates the artificiality of "do as I say, not as I do." Private sessions at different times with different team members in brief therapy seem to give a clearer opportunity to test the reality of the affirmation accorded the patient's ability to develop a capacity for intimacy than is possible in the situation where a single therapist sees him only in family group situations at weekly intervals.

THE THERAPISTS AS INDIVIDUALS

As individuals, the team's therapists had professional identity as psychiatrists, psychologists, and social workers. Their competence and respect for each other in their respective fields were important ingredients in their being able to help others shape their identities. Confidence in themselves as individuals and as specialists was a necessary ingredient in their ability to transmit self-respect along with respect for the patient. Transmission of therapists' belief in the worth of the patient appears to be a basic ingredient in the development of family therapy. As noted by Charen et al, "The faith of the patient in the therapist has been discussed in other papers, but commitment to work with the seriously disturbed family in particular presupposes the therapist's faith in the family" [3]. In our family approach we found it important that this respect should also be transmitted at the individual level.

Evidence that satisfactory identity within the therapist's own discipline was a significant factor in the success of MIT was gained from a number of situations in which the team included professionals who rejected their specialty for the identity which all team members had, that of psychotherapists. When one team member abandoned his specialty—the medical diagnostic role of the psychiatrist, the psychological examining role of the psychologist, or the evaluation of social data in the back-home situation by the social worker—the rest of the team could not have confidence in

the use of MIT, and tended to prolong the procedures. As an individual the therapist provided a model for individual identity to adolescents whose fear of emancipation was associated with a fear that their only claim to significance lay in identity with a family group. It appeared important not to affirm such a fear by excessive group identity on the part of the therapists.

Staff members of other clinics and our own directors suggested the possibility that the method might be the product of a unique ability to work together which characterized the particular team that developed the method. This hypothesis was tested by replacing each member of the basic team several times by other professionals, and by each of the basic team members going to other clinics to participate in MIT with a competent orthopsychiatric team new to this particular method. We found that the method was not tied to the interaction of a particular team; any competent team that considered the method worth a vigorous attempt was able to use it effectively.

In this study of roles we noticed that just as there is a division of functions among members of a family, or members of therapy groups and work groups, there is a division of function in the team. These functions tend to be performed by the person best suited for them, but when that person does not perform them, another member of the group does so. The psychiatrist tended to stress the genetic approach, particularly the understanding of early life situations of the parents. When the psychiatrist who used this approach was not present, any other basic team member performed that function. The psychologist tended to analyze the group dynamic process of the therapeutic session. When the psychologist was replaced by a colleague from another clinic in several cases, the regular psychiatrist on the basic team reported that he had almost unwittingly performed the psychologist's function. In fact, this emphasis on process analysis was the function performed by each of the team members when they trained teams new to the method but otherwise skilled in psychotherapy. Dependability in recording data, and skill in finding information about community resources and

about the objective facts and reality situations that the family must deal with on return home, are essential to the method. Where the social worker did not perform these functions, other members of the team did.

Professional Qualifications of Team Members

As we discussed in the historical introduction, the basic team and the project directors were like-minded on many matters of psychiatric theory, and the group members had worked together enough to have considerable confidence in the personal and professional qualifications of each other. In a pioneering article introducing multiple therapy but based on three years of experience with the method, Whitaker, Warkentin, and Johnson [4] stress the importance of co-therapists becoming aware of their major differences before inflicting them on the patient. Many, including the above authors who work intensively in psychotherapy, conclude that personal analysis for the therapist is a *sine qua non*. While we are inclined to agree with those who regard analysis as important, MIT, by its provision of many situations to check on the blind spots of team members, offers a way to make maximum use of the many who have only partial understanding of their own problems.

Not only should basic team members be well trained in their respective disciplines; they should also have experience in both individual and group psychotherapy, since the basic plan of MIT includes a combination of the two techniques.

In addition to professional qualifications of team members, more than formal ability to collaborate with other professionals is required. Collaboration in this work includes not only the professional respect necessary to listen open-mindedly to colleagues and to consider their opinions and anticipated course of action, but also sufficient security in one's own competence to present, forcefully if necessary, an alternative evaluation and set of recommendations. The ability to compromise occasionally when agreement or convergence cannot be reached is implied.

THE TEAM

The setting of the therapy, since it requires working in the presence of others, makes special demands of flexibility which team members should be able to exemplify. Sometimes a skilled therapist experienced in work with individuals may have difficulty in shifting his normal focus in treatment from a patient to a family group as the patient unit. The overlapping sessions seemed to be the most difficult and even threatening aspect of MIT for a therapist used to being *the* therapist to an individual or group. In those sessions he was expected to reveal to a colleague in the presence of a patient some of the content of an interview, selected impressions, or interpretations.

It can be observed readily that a certain possessiveness sometimes pervades the vocabulary, and also the attitude of some therapists. They speak of "my patients," "my records," "my therapy group," "my ward." When a therapist actually is consciously or unconsciously possessive of the patients or group of patients he treats, he has difficulty in almost any collaborative effort, and he is acutely uncomfortable in the give and take which is essential for the success of MIT.

TEAM INTERACTION AND LEADERSHIP

Something of team interaction has been described earlier, but it seems important to mention a "division of labor" within the team which is in many ways the counterpart of the division of functions within the family, one of the concepts on which this family therapy is based.

Division of labor within the team is not exclusively determined by matters of status, professional discipline, and seniority. Our experience indicates that an MIT team should not only include members of various disciplines but also of both sexes. The personalities of the individuals, their relationships and interactions, all contributed to the role and status in which each functioned. The reader will recall that leadership has been defined as a normal aspect of aggressive functioning as represented on the circular chart, and that criticism is a normal aspect of passive-aggressive

functioning which is represented in the lower right quadrant of the chart. When one member functioned in an aggressive way, for example, when the doctor closed the group discussion of Rocky's dating, he assumed considerable direction or leadership. Frequently, one or more of his teammates would respond in a more passive-aggressive manner, with mildly delaying maneuvers. At that time a team member protested, "No, we need more meaningful discussion of Rocky's dating, not less of it!" Typically, such intervention from the one in a passive-aggressive position contributed criticism to the interteam communication. Under some circumstances when the aggressive versus passive-aggressive tension was strong, another member assumed temporarily a quite passive role, functioning more as a learner or a beginner who was dependent on the leader. In the above example a visiting clinic director was the one who, dropping into the passive position, asked a polite question as to what was usual procedure at this point; a gentle reminder, perhaps, that he too was to be considered a beneficiary of this therapy. When two members seemed to be competing for leadership in the group, one of the two tended to give vent to more exaggerated or fanciful speculations and interpretations of behavior or family dynamics, thus enjoying temporarily the role associated with the function labeled, when extreme, "emotionally unstable." In its healthy aspects, as described in Chap. 5 on family dynamics, this is the role that contributes spontaneity, creativity, and playfulness. In the example the therapist who had had leadership responded to the critical team member not by claiming authority but by submitting a creative insight; namely, that Rocky's dilemma at home paralleled his situation in the group. The critical member then became the "leader" who endorsed the recommendation to end discussion.

One outstanding characteristic of the MIT team is that leadership is not static. Leadership roles are affected by the character of the team and by the nature of the project as well as by the needs of the particular patient family. The members of the basic team are essentially peers, each with a particular area of competence,

and also with a considerable amount of shared or similar knowledge and skills. Under these circumstances when therapy was effective, competitiveness resolved into collaboration. This was possible when the goals of the various team members were understood by other members and were consistent with the goals of the project. It goes without saying that all team members feel personal and professional responsibility for ensuring that the patients' experience in the clinic is therapeutic and not either useless or traumatic. Similarly, during the research-demonstration phases of the project, all team members wanted to test the efficacy of this particular treatment method, as long as the testing was not inimical to the patients' interest and welfare.

The original tentative plan for evaluating the efficacy of MIT had been to use the procedure as a definitive method of treatment, uncontaminated by other therapies such as tranquilizing medication. Clinical judgment, however, made it necessary that such adjunctive measures be used. When the psychiatrist on the team felt convinced that medication, or in the case of one psychotic patient, hospitalization and electroshock therapy were advisable, the leadership he exercised in his area of competence prevailed, and these treatments were used in addition to the MIT.

Leadership is temporarily assumed by different team members in various areas, as illustrated by the following example.

Milton Head and his adoptive father returned to Galveston for MIT about a month after the screening session. During the morning conference both Milton and his father presented a rosy picture of all the former problems solved and all conflict between them resolved. A tentative decision was made by the team at the noon luncheon conference to limit MIT to one day, leaving the door open for the patients to return when a problem arose. There seemed reason to believe that the adoptive father had strong but unconscious and unexpressed homosexual feelings toward the boy, but it was considered unwise and untimely to stir these up into consciousness. The plan of terminating that afternoon was presented to Mr. Head early in the afternoon and accepted by him. However, in another office Milton was beginning to verbalize his dissatisfaction with his father's overpossessive and over-

restrictive control. Mr. Head had expressed some mild concern that Milton had few friends. Milton now complained of his father's requirement that he spend most of his free time in recreation or chores with his father, and that he study alone at home, and not visit schoolmates or invite them to study with him; that in fact his father permitted him very few opportunities for making friends or socializing. This new information, of course, forced the team member in whom Milton had confided to reopen the question of appropriate length of service. This matter was discussed in a team-family conference, and the noon decision reversed. The second day of MIT, plus scheduled follow-up, was used.

In group and multiple-therapist sessions, when a problem was brought up or intervention was appropriate, ordinarily one basic team member assumed leadership by stating that he had an approach to the problem. When this went counter to the plans of others it was occasionally necessary for that team member to insist that he should be heard. Signaling methods not understood by the patients as well as by the team were not used. When situations arose which clearly called for intervention or interpretation and when none was forthcoming, a team member usually addressed another: "Dr. X., what do you think?" or "Dr. Y. is our expert in matters of this kind." Not infrequently one team member sensed while speaking that his comments were either inadequate or inappropriate, and asked for correction or for supplementation by another team member. Such requests occurred especially in overlapping sessions, or in group sessions on the second day and in follow-up meetings. Rather than being received as "buck passing," these requests were usually taken as indications that the person making them wished enough freedom from involvement to make a more creative contribution.

Because team members were able to allow themselves involvement with family members to such a degree that there was often some loss in perspective, a contest for leadership sometimes resulted. This is illustrated by two case examples already cited. In the overlapping conference of the psychologist with Mrs. Jones and the social worker (Chap. 2), it is clear that both team members

are vying with each other, each wanting to present the needs of the patient he has temporarily identified with, to be spokesman for that patient to the family and to his teammates.

In the case of Milton Head and his father, cited above, the recognition of the boy's readiness to work on family problems was the direct outgrowth of relationship established with a team member, who then took leadership and suggested the change in plans previously agreed on by the team. In that situation, the entire team was quite ready to follow this suggestion, and no real rivalry in the team developed.

However, there may not always be harmony in the team, as in the following illustration.

In a case which was studied by the team as a part of intake procedure, but which was not considered appropriate for this type of treatment, the psychiatrist established a warm relationship with a very unhappy and emotionally deprived lad, and attempted to persuade the team to go along with the boy's request that he be allowed to go immediately to live with an aunt in another state. This aunt, an unmarried school principal, had apparently taken an interest in the boy during his early childhood, but there had been no contact or correspondence for several years. She had not volunteered to help at all during the tragic period when the boy was deserted by his mother, abused and exploited by his father, and finally placed by county authorities in an institution for dependent and homeless children. His adjustment there was poor because of his difficulties with authority. The doctor was convinced that the boy's problems were primarily with male rather than female adults and authority figures, and he was even prepared to recommend that the boy be put on a bus or train to go to his aunt's home rather than return from Galveston to the institution where he was so unhappy. The social worker, who had previous experience with a child placement agency, was adamant about not permitting such a recommendation, insisting rather that a careful preplacement study was essential, to evaluate the aunt's current attitudes toward the boy as well as the practical questions of her ability to provide a home and financial support for him.

This was clearly a question of leadership in the area of competence of a team member, just as in an earlier illustration, when

the psychiatrist's recommendation for hospitalization and electroshock treatment for a chronically psychotic adolescent prevailed over the thinking of other team members that family-centered therapy alone should be attempted before any somatic treatment was used.

The division of labor among team members and the competition among them for various roles has been discussed. In other sections we have shown that real competition exists where there is not a feeling of deprivation and of scarcity. This is an activity enjoyed by healthy people, and it stands in contrast to behavior in sick situations where individuals are forced to function excessively in a particular role. Emphasis should be placed on the fact that opportunity for patients to experience competitive tensions directly with the team is part of the way in which the team becomes known to the family. The team likewise experiences the family tensions directly, so that the team members may converge to achieve compatible if not identical plans and recommendations.

Countertransference Problems in Team Collaboration

The difficulties in the way of successful collaboration in any team effort are manifold; insecurity and professional jealousy may occur between team members of the same discipline attempting to work together, and they are perhaps even more likely in a multidisciplinary staff.

Some of the problems of inharmonious intrateam relationship in family therapy are described and analyzed in an interesting paper by Brodey and Hayden [5]. The diagnostic value of observing the intrateam reactions is emphasized. "In varying degrees, these actions are a reduplication in diminished form of the family conflict."

Our experience has been comparable, but with some differences. We have attempted to capitalize on the relationships (transference and countertransference) between individual team members and individual family members, and on the differences in opinion and interpretation within the team, not only as diagnostic clues but as therapeutic agents. In team-family conferences and in multiple-therapist sessions, the team reflected back to the family the inter-

action between family members, their distortions of reality, and their struggles and maneuvers to control, exploit, or dominate. The team interaction, however, is on a healthier level. Differences of opinion or of interpretation are accepted, verbalized, "argued out," or sometimes argued without resolution but also without rancor. Empathy or even partisanship for individual family members is openly expressed by team members and freely criticized by the rest of the team. The correction of misunderstandings and distortions is facilitated by this freedom of communication. Efforts of individual team members to dominate or control (assume leadership) are also open and straightforward, without subterfuge. A particularly important point of technique in these multiple-interaction methods is that the team can and sometimes does reject the leadership of a team member, and that he does not lose face; his next idea or suggestion is considered by the teammates and accepted or rejected as they deem appropriate.

We have found that the MIT procedures are frequently effective in preventing or correcting the difficulties or overidentification of a team member with one patient, and critical or hostile attitude toward other family members. The exchange of family members who are seen, and especially the participation in family and two-patient conferences, as well as team conferences, help to make vivid to each team member the strengths and the weaknesses of various family members, and the pathological interaction between them.

On one occasion, a young trainee with little or no clinical experience participated (largely as an observer) in MIT. He was present at the opening family-team conference and later in the first morning during part of the interview between the team psychiatrist and the adolescent nominal patient. At the beginning of the team's luncheon conference he was eloquent in his hostility and criticism of the mother. He clearly perceived that her aggressive and controlling role in the family was pathological, but did not perceive the pathological passivity of her husband which tended to force and keep her aggressive. He was also insensitive to the hurt and frustration the mother felt about her own shrewish behavior.

The more sophisticated observations and evaluations of experienced

team members at the luncheon conference provided clues for this trainee not only to observe the pathological conditions in other family members, but to notice his own naïve overidentification with an unhappy adolescent clumsily seeking autonomy and emancipation, and his equally naïve hostility toward authority as embodied in the unhappy, overprotective mother.

Since no one is free from blind spots, experienced and relatively mature therapists may become overinvolved or overly critical of a family member. Early in the work with the Jones family the social worker began to perceive Mrs. Jones as an aggressive, controlling woman (much as the trainee mentioned above perceived another mother), and to react in a hostile manner toward her. During the overlapping session, Dr. MacGregor's expressed concern and compassion for Mr. Jones served as a corrective measure and helped to mobilize in Mrs. Ritchie the empathy and compassion appropriate to Mrs. Jones's unhappy situation (p. 32).

Near the end of the work with another family, Dr. MacGregor became quite concerned about the limited time a seafaring father spent with his wife and children, and began to point out to him in a somewhat hostile way how his absences from the home contributed to family problems. Other team members quickly intervened to support the father in his choice of a means of livelihood, and to remind Dr. MacGregor of his own frequently stated opinion that the attitude of the father and his relationship with his family are more important than the length of time spent with them.

It is possible that Dr. MacGregor's mistrust of Dr. Serrano's ability to handle his feelings about Mrs. Jones in a therapeutic way (p. 35) was related to and was a reflection of the lack of trust in this family, especially the distrust of each parent for the other.

The diagnostic use of a group impasse is illustrated by the work of a visiting clinic director participating in the Antanias case.

In a team-family conference the visiting psychiatrist pointed out that the family had caught the team up in its pattern of avoiding responsibility for decisions, and that while the team seemed to be working hard

producing ideas for them, the family was just egging them on by rejecting all ideas. Thus it appeared that if the nominal patient did not return to school the family would have it that the team, not they themselves, had failed to find a solution. This challenge was followed by a rather masterful, dynamic summary by the father of the problem and several possible solutions, and by the family's choice of a course of action.

In another more typical situation two therapists were competitively stating a problem, each in agreement with the other but each preferring his own terminology. This sort of tension alerts the team to wonder about the family's part in such an occurrence in a group setting. One of the two doctors asked the family if they always stimulated such competitive activity in others. This led the parents to reveal their acceptance of a formulation, made to each in individual sessions, that they had allowed a competitive relationship to develop between them to displace the possibility of either one really letting the other get to know him.

An important advantage of a team rather than the single therapist working with a family group is just this exposure of the family to these tensions in the team and its interaction. The flexibility of the therapists in shifting and exchanging roles serves as a model for adaptability. The family may see itself reflected in the team, which also faces differences of opinion in solving problems. Family members observe that a mature, experienced doctor who is competent and comfortable as an authority and a leader can also, without loss of face, occupy temporarily a passive role while others assume active leadership. Team members are free to disagree without loss or even diminution of liking or respect for each other.

EXPANDING THE BASIC TEAM

The basic team was frequently expanded so that the number of team members equaled the number of family members, thus permitting simultaneous individual interviews with each family member and providing a learning opportunity for other professionals or students. The two functions of expanding the experience with the

family and of augmenting the teaching of psychotherapy and family dynamics are treated together in this section.

The way in which the basic team was expanded is illustrated by the following example. An additional psychologist to administer psychometric and psychological tests was frequently included in the team. This added person released the time of the psychologist in the basic team for more active and continuous participation in the therapeutic endeavor. The additional psychologist, usually a trainee, was rarely assigned only the task of administering a battery of psychological tests. He participated in team conferences and in the family-team sessions. He discussed his findings and impressions with the team, and frequently presented these to the nominal patient and the family. This was done under the supervision of the staff psychologist and usually in a multitherapist situation with one or more of the basic team present.

Early in the existence of the MIT team, a young psychology resident was incorporated into the basic three-member team as an auxiliary member. He was well trained and had some experience in administering various psychological tests and in preparing quite adequate reports on the tests for the referring persons, usually psychiatrists and occasionally school personnel (teachers, principals, and counselors). However, prior to his experience in MIT he had had little or no training or experience in interviewing or therapy. His eagerness to acquire experience in these areas led to his requesting and receiving permission to present and discuss his test results privately early on the second day with the mother of a moderately disturbed adolescent patient.

This trainee's fascination with the fanciful and sometimes bizarre responses to the Rorschach cards led him to report almost literally on the tests to the mother. She was not only shocked at the content of her child's fantasy life, but concluded that the lad was very sick indeed. The unnecessarily severe anxiety engendered in the parents was alleviated by painstaking interpretations and reassurance by other team members later in the day.

It was out of this experience, and one or two others somewhat comparable very early in the project, that the practice grew of having novices present only at multitherapist sessions until they developed and demonstrated clinical judgment.

Community Representation on the Team

When possible, a community representative involved in family problems was included as an auxiliary team member. Many of the children and their families who come to the attention of guidance clinics have previously been referred to various community agencies, such as family counseling agencies, child welfare services, clergymen, or probation departments. It is a generally accepted practice that some sort of communication is set up between the clinic and such agencies. In this research demonstration project we have experimented with a much closer kind of study of the community relationships of families, and collaboration with community resources. Just as an adequate evaluation of a child or adolescent can be made more rapidly and accurately when there is an understanding of the family, so the family can be more clearly understood and evaluated if viewed in relation to the community—more so than would be feasible without some awareness of the community mores and those community agencies with which the family is involved. Two methods were used to increase our understanding of the communities and their resources. Agency staff members who had worked with the families were invited to participate with the team in all or part of the MIT procedures with the family. As indicated in Chap. 3, many of the follow-up visits with families were made by the team in the family home or in the community, and these usually involved visits to community agencies.

The collaboration of a representative of a community agency as a temporary team member in the work with the family proved useful. When one or more members of the family were suspicious, apprehensive, or even doubtful of the clinic and its staff, they were reassured by the presence and participation of the social worker or community representative whom they already knew and trusted. This was particularly true of the situations in which a hospital chaplain functioned in place of the community representative. When present, the community representative functioned on the first

morning as a liaison between the family and the team. In the eyes of some families, his very presence vouched for the competence and integrity of the clinic staff. The chaplain was able to win the trust of Peter Jones (p. 36) after others had failed to do so, and it was to the chaplain that Peter handed his switchblade knife. This gesture seemed to symbolize clearly Peter's new appreciation of his own worth and strength, so that temporarily at least he no longer needed a knife or other property to prove his manhood.

The agency staff member or community representative was in a position to inform and educate the clinic staff about community conditions and customs. He could point out limitations imposed by the realities of local resources including those on employment, child placement, and opportunity for special education, as well as such specific limitations as the probation or parole conditions set by the court for a juvenile offender. It is sometimes true that guidance clinic staff members become so occupied with psychological and emotional problems that they lose perspective on some of the environmental and social factors affecting their patients.

The MIT collaboration frequently has been an "in-service training" experience for the community representatives. Even a competent and conscientious caseworker, visiting teacher, or probation officer, working with one or more family members around specific problems appropriate to his agency, seldom is able to explore and evaluate the extremely complex patterns of personal adjustment which, more often than not, are involved in family difficulties.

Community representatives have not ordinarily participated in the same way as the members of the basic team. They were present at the opening family-team conference, and were invited to team luncheon conferences and other team sessions; they have been present at times as observers or participant observers in interviews with one or two family members in overlapping sessions. On at least two occasions, when the lack of skill or negative attitude of the community representative made it advisable to protect the family from him, he was kept occupied with conferences with our staff members about various matters including the family in question, inter-

agency communication and cooperation, and community conditions, or with various records and reports. However, this exclusion was rare. In every instance an important goal was to provide the visiting community representative with an opportunity for broader and deeper understanding of the family involved, and to enhance rather than decrease the family's respect for him and any constructive working relationships already developed with him.

The home visits and the personal contacts with key individuals who were significant to the families also contributed to the team's effectiveness. A sojourn of one to three days in a town provided many opportunities for observing community standards and patterns, for personal meetings and interviews with family doctors, clergymen, school principals and counselors, county and district judges. Being participant observers in agency staff meetings and attending community functions, luncheons, and evening meetings of such organizations as the local chapter of the Texas Social Welfare Association provided the team and the clinic with information about local resources; it laid the groundwork for a kind of mutual understanding and coordination of effort.

Formal participation by a clergyman in a clinical team is a comparatively recent development, reported by Gluckman in 1953 [6]. Two different Medical Branch chaplains have participated as team members in the MIT work with three families. In these families there was evidence of religious conflict in one or more family members, but in none of the families was there evidence of religious fanaticism or extreme preoccupation with church or religion.

Other Trainees and Colleagues

Somewhat analogous to the presence of community representatives was the inclusion in the MIT team of a therapist who had worked previously with the nominal patient or a member of his family. Most frequently in this teaching hospital it was a neuropsychiatric resident who had known and worked with the adolescent patient during a period of hospitalization. This is illustrated in Chap. 2 by the participation of Dr. Y., the psychiatric resident, in

the family therapy with Peter Jones and his family. The relationship and the confidence built up between the hospital doctor and his patient served to reassure patient and family, as did the presence of the community representatives described above. The MIT experience has added to the training of these residents a depth of understanding of the patient and of family dynamics.

In selected cases, other medical specialists were used on the MIT team. For example, when the intake conference with one family revealed that the father suffered from long-standing gastric ulcer symptoms, an internist joined the team for the work with this family. A pediatrician and several pediatric residents have become temporary team members in the work with families where younger children had presenting problems of behavior or adjustment. No allergist has been available to participate in this particular project, but our conferences with pediatric allergists indicate that inclusion of this specialty in work with families where asthma or other allergic disorders are problems would appear advisable when possible. The consultation services of neurologists, gynecologists, and other specialists have also been used.

On various occasions competent therapists from other agencies were included in the MIT team at their request for the purpose of learning the method by participation and of evaluating its usefulness for their own agency settings. Such participants included psychiatrists, psychologists, and psychiatric social workers from community guidance clinics and outpatient clinics, and staff members from the three mental health professions in this medical center. Moreover, each member of the basic MIT team of the Youth Development Project was "loaned" by request of another clinic or hospital to orient an established orthopsychiatric team in multiple impact therapy.

Experience in teaching the method to visiting clinicians and in visits to other clinics led the team to organize exposure to the method into a short course or institute lasting perhaps four or five days. Regardless of whether the clinicians to be taught came on fellowships, on sabbatical leave, on the distant clinic's budget, or

at the expense of this Project, only those were accepted who could also be regarded as consultants who might contribute to some phase of the Project's development as a result of the training.

Before the visit, the Project provided the trainees with reprints of articles describing the method. In anticipation of the visit, commonly starting on a Monday, a family was scheduled to be seen on Wednesday and Thursday. Monday morning was occupied with team and visitor becoming acquainted with similarities and differences in each other's clinic situation, therapeutic orientation, and way of speaking. In the afternoon the tape recording condensed from the Jones case, with the typescript, were presented. This material is substantially that which appears in Chap. 2. The consultants-in-training were asked to listen with a view to letting us know later of their evaluation of the tape and script as teaching material. The hour-long tape was interrupted periodically through the afternoon to allow thorough discussion of the case. Some evenings were used for further study of written materials on which the team needed consultation, others were used socially to enable the trainees and consultants to know our professional associates. Tuesday morning was devoted to relating the method presented the day before to theory and in gaining criticism, implications, and applications of the method that had occurred to the visitor. Tuesday afternoon the data concerning family to be seen the next day were discussed. This was a fuller discussion than in most team conferences and was used in particular for exposition of the typology described in Chap. 4. The last day of the visit was reserved for group dictation with the participating visitor and for discussion of any aspect of the Project or its report to which the visiting clinician seemed best able to contribute. Few visits went exactly that way. An intake rather than a two-day session had to serve for shorter visits, and frequently the visiting clinician left with dictation and comments still to finish and send by mail. The team has kept them informed of follow-up data, and the visitors have rewarded us with subsequent reports of their experiences with MIT and with the use of our teaching methods [7].

Medical students, social work students-in-training, psychology residents, and psychiatry residents have all participated in MIT as part of their training experiences here. In the multiple-therapist sessions of MIT the student observes experienced therapists at work. These experienced therapists, as teachers, observe the student or learner and have an opportunity to perceive his attitudes toward

patients and his ways of relating to them as well as the appropriateness of the timing and the nature of his interventions and contributions to the discussion. The amount and nature of the participation of each student or learner was controlled and regulated according to the stage of his professional development. Completely inexperienced beginners took part only in group sessions. The trainee with more experience spent time observing a small child in the playroom or taking him for short walks while the basic team worked with adults and adolescents. Where a trainee demonstrated considerable professional judgment and maturity he was expected to participate as a full team member, in both group and individual sessions.

SUMMARY

An evangelical tone in this chapter suggests that we have difficulty in describing our teamwork objectively. Some wise counsel has been given concerning writing about interdisciplinary research by Elizabeth Herzog in a Children's Bureau Publication, *Some Guide Lines for Evaluative Research*.

Interdisciplinary research seems to resemble love in the fact that it is vastly written about and yet when it happens to a person it feels new, unexpected, uncharted. It fills him with a desire to tell others all about it, and very often he does—without quite realizing that *this* is what all those pages and pages he has read were about, and that his testimony will probably be as fruitless for his listeners as the accounts of others were for him. Again and again, with a sense of discovery, both researchers and lovers try to explain what it means, what it demands, and what it feels like. But for all that, no one ever seems able to prepare anyone else or to help him avoid the pitfalls so often and so eloquently described.

Interdisciplinary research, unlike love, has standard early phases that are usually wasteful and often painful, and that seem avoidable to those who have lived through them. The many pages written on the subject represent an effort to help others avoid these phases. Yet these efforts, on the whole, seem more successful in producing hearty agreements from those who have lived through it than in forestalling interdisciplinary growing pains for those who have not [8].

Our very involvement suggests that in the team we deal with family-like processes. Visitors to the Project, however, wisely point out that the family does not perceive the team in terms of family-like processes because the family accepts us as professionals, each having his own family. Martin Grotjahn [7] suggested that the team functions more like the chorus in the Greek drama. This analogy is more satisfying in view of the way that in team-family conferences the team represents public morality, while in individual sessions private morality may be explored. The practice of one member sketching a rather complete dynamic theme in the very first conference reminded him of the role of the blind seer Teiresias in the Oedipus myth. Certainly the response to that particular tactic is often a chorus of protest.

Since this is a demonstration project rather than evaluative research, our goal is to describe what we did, but with sufficient information on relevant variables so that MIT may be compared with other methods of psychotherapy. In this chapter we have described the relationship among teammates and have added something to what has been said in other chapters about the relationships with the family and family members. We have also indicated that there are special features of MIT which enhance the relationship to the patient's community.

Because the outcome of psychotherapy is so obviously related to skill, we have shown a number of ways in which the quality of the therapy was controlled: participant observation of therapists by colleagues and supervisors, protective intervention, requirements of individual competence, and replacing team members to determine which roles seemed a function of the method rather than of persons.

In the process of studying the therapist, we found we also had developed a useful adjunct to methodology of supervised training in psychotherapy. Certainly, MIT has provided a way to let the medical student and other students get a closer look at family dynamics. Experience in MIT also appears useful for helping a staff to become a team.

CHAPTER 7

Results

Results of this mental health demonstration project are considered under the several headings of its objectives. The use of MIT as a method of research observation which yielded new typology and the formation of new concepts in the area of family dynamics was presented in Chap. 4. Evidence that the treatment method has suitability to a wide variety of cases was presented in Chap. 5. The evidence for the usefulness of MIT as a method for supervised learning of psychotherapy, for teaching in the area of family dynamics, and for staff development was presented in Chap. 6. The present chapter describes the procedures for evaluation of the method of therapy, the kind of processes which were considered to be movement in psychotherapy, and the evidence which indicates the outcome in this method warrants its consideration along with established methods of psychotherapy. The status of methodology in outcome research in psychotherapy is not yet that of an exact science. For this reason, in previous chapters an attempt has been made to provide a basis for comparison with the work of others by thorough description of the variables which currently are considered to have a determining influence on the results of therapy. These variables include the theory, the method, the patient, the therapist, and the skill with which the therapy is applied.

POPULATION, REFERRAL, AND SELECTION

In order to evaluate the therapy in terms of the gross criteria appropriate to a demonstration project, the clinical research team accepted for study a population of families presenting mental health problems at the severe end of the range usual to outpatient psychiatric clinics. The team further regulated intake only to guarantee that the population studied should have variety in regard to ethnic and socioeconomic factors as well as in psychiatric problems.

A total of 62 families, 21 in the first year, 21 in the second, and 20 in the third, were treated with multiple impact therapy.

Referral sources were primarily physicians, schools, and social agencies, including governmental agencies such as probation departments and juvenile or county courts. Over half the cases were referred while the adolescent was a patient at the Medical Branch hospitals or at outpatient psychiatric clinics elsewhere in the state. Many of these cases had been referred to the psychiatrist or to the hospital or clinic by a local physician or agency. In other words, referrals frequently occurred in two steps: the local physician or agency referred the patient to a psychiatric facility, which in turn referred the family to the Youth Development Project. In Table 7-1 the treated cases are tabulated by final agent of referral.

Table 7-1.

PROXIMATE AND DIRECT SOURCES OF
REFERRAL OF TREATED CASES

Psychiatric hospitals:			
MIT initiated as a hospital discharge procedure . .	11		
Intake conference at time of discharge	8		
Intake conference 1 or 2 weeks after discharge . .	<u>4</u>	23	
Outpatient psychiatric clinics		9	
Social agencies:			
Family service agencies	2		
Juvenile courts	<u>7</u>	9	
School system (principals, nurses, counselors)		6	

Table 7-1.

PROXIMATE AND DIRECT SOURCES OF
REFERRAL OF TREATED CASES (*Continued*)

Private practitioners:		
Psychiatrists	10	
Internist	1	
Gynecologist	1	
General practitioner	1	
Psychologists	2	15
	<hr/>	<hr/>
Total number of cases treated	62	<hr/>

Cases were taken in order of application or referral. Waiting lists were not kept, and families were referred elsewhere when intake had to be closed. When it was apparent that a particular socioeconomic or cultural group was underrepresented, preference was given to that group. For instance, when we had had no experience with Negro families, intake was then open for a time to this group only.

Because the investigators were interested in finding out more about the types of cases for which the method was suitable, only a few limitations were placed on eligibility. Mental deficiency, chronic and acute brain disorders, and gross psychosis were ordinarily excluded. Work with a few families whose members did not live together led the staff to make the requirement that the nominal patient live in a family group that could be represented at intake, be present for the MIT sessions, and be available for follow-up in the home community or in the office. Usually, when the referral data indicated that court appearance as expert witnesses was expected of the team, the referring source was advised to seek other resources, with the assurance that MIT could be considered after the legal problems were settled. The demonstration team did, however, work with several chronic and acute schizophrenic adolescents as well as with youths under indictment. Families were not rejected for treatment on the ground of having been coerced by local law-enforcement agencies into accepting MIT.

MIT has ordinarily been done with families whose understanding of psychotherapeutic work was meager. This was partly because the distant referring agencies were frequently not seeking psychotherapy for the patient or family, but desired hospitalization, investigation of particular symptoms, or other aid in dealing with the family crisis. The Youth Development Project in the medical school was not considered by the referring agencies to be the usual child guidance clinic.

Fathers who had not been able to take time from work to participate in other services or activities involving their children found it possible to arrange a three-day trip. It proved easier for less well-motivated families to schedule two or three days, even though the service might be 400 miles away, than it was for various members of the same family to meet regularly scheduled appointments over a period of months in their own community. This factor proved true for local as well as for distant families.

The financial situation of the family was not relevant, as fees were nominal or were waived for low-income families. County judges, probation officers, child welfare workers, and other agencies helped supply transportation or funds when necessary. As the knowledge of the work of the Youth Development Project spread, particularly in the third year, an increasing number of families of higher socioeconomic status applied for service, usually referred by private physicians.

Because this is not usually a clinic of first resort, in most cases the manifest patient was emotionally disturbed to such a disabling degree that ordinarily long-term treatment methods or institutionalization would have been prescribed. In all cases the situation at referral without intervention would have led to some form of exclusion of the youth from the community or to a breakdown in the family.

DEVELOPMENT OF EVALUATION METHODS

Follow-up information on all families was obtained at 6 and 18 months after the initial procedures to determine whether the

need for institutional or other intensive care had been averted. One-half of the families were restudied at the same intervals of about 6 and 18 months by procedures resembling intake to determine whether the social, occupational, and educational adjustment of the manifest patient showed change and whether family self-rehabilitative processes had been indeed mobilized.

In addition to these gross criteria, families were re-evaluated in terms of the problem areas that each initially presented. To carry out this aspect of the study, the *dictation outline*, reproduced in note 4 to Chap. 3 in Appendix B, was developed to ensure that the same factors would be summarized for study from case to case and through time. The headings of the outline included usual social, psychiatric and psychological topics such as *relation to authority* and *relation with peers*. Since psychiatric classification in childhood and adolescence is particularly unstable, the team deferred the psychiatric description of the population until categories based on experience could be developed. To identify and describe types of patients the research team analyzed the content of the dictated summaries for recurring patterns under each heading. Such headings were then adapted and transferred to a *research outline* (Table 7-2) used in the analysis of the dictated data. This analysis yielded behavior patterns for four tentative patient-family syndromes representing very different levels of behavior.

Relation to Authority is an example of the dictation outline headings. This particular heading was selected as an illustration because the adolescent patient's relation to authority was an important aspect of the family's problem, and frequently was the precipitating factor that led to referral to a psychiatric clinic. From the relation to authority typical of each syndrome came the terse descriptive titles used for three types. Representative entries under this heading follow:

Rebels (Type D): Pseudo rebellion which asked for the setting of limits: this appeared not to be directed toward attaining freedom but was associated with exaggeration of preadolescent gang standards.

Intimidated Youth (Type C): An anxious, fearful group whose mis-

behavior had as its goal the winning of acceptance from a leader: they appeared to be intimidated by authority and not attuned to peer-group standards. In a manner typical of H. S. Sullivan's "juvenile era," they seemed preoccupied with problems of competition and compromise.

Autocrats (Type B): An unsocialized, aggressive group who in their transgressions, typical of early childhood, showed little awareness or recognition of authority. In contrast with the rebels' fascination with authority, these youths dealt with others only on their own terms and generally avoided recognition of limits to their own powers.

Six Schizophrenic Patients and Their Families (Type A): These were infantile, autistic youths who had their authority problems with parents and only accidentally involved others.

Under the heading *Family constellation* in the research outline another series of patterns was accumulated for the interaction which characterizes the families of adolescents of each type. The concept of the family constellation was developed from a scale which Dr. Franklin P. Schuster, Jr. had devised in military service [1]. His was a schedule for diagnosing patients insofar as they manifested four immaturity reactions then described in the United States Army nomenclature. Schuster represented aggressive, passive-aggressive, passive-dependent, and emotionally unstable functioning clockwise as four quadrants in a division-of-labor scheme, whereby, for example, the aggressive or emotionally unstable behavior of one person was compensated and also maintained by the passive-aggressive and passive-dependent functioning of others.

This seemed to be a useful matrix on which to represent graphically some immature aspects of the family interaction, for example, the husband-wife interaction as it influenced and was influenced by the children. A similar diagram (Fig. 3-1) was used in the team's briefing session at the opening of the two-day procedure to develop a plan of action on the basis of the intake and referral data. In our diagram the center has been "opened" and represented as an inner circle. Within that circle maturing processes function, fostering creativity, for example. It is an open system where the mutually compensating attitudes are tempered by role flexibility and receptivity toward new encounter.

While the immaturity reactions were not used as the diagnoses of the children or their families, they appear useful to describe dimensions in the family constellation. Recent studies indicate substantial agreement on these or similar attributes as real dimensions of interpersonal relationships. Earl S. Schaefer in an article, "Converging Models for Maternal Behavior and for Child Behavior" [2], has shown that mathematically defined factors from several significant psychometric and research approaches can each be reduced to a similar fourfold scheme of personality dimensions.

Such empirically derived behavior patterns were accumulated for other headings, including *exploitation*, *sibling situation*, *sex role*, and typical way of handling *anxiety*, to provide a detailed set of specifications for four syndromes. Initially, under each heading a descriptive statement—or a cryptic one such as "like the Jones case"—was used. Repetition led to retreat into literature for rubrics. There was "the Cordelia role" under "relationship with father," and "the Jacob and Esau syndrome" under "sibling situation" where the nominal patient seemed to sell out his birthright to a more dependable younger sibling. Empirically in this way a limited number of statements appeared under each of 25 headings. Tabulation of the first half of the case load under these headings yielded the four types presented in Chap. 4. Redundant categories were eliminated to bring the number down to 17.

The selection of types and the behavior used to describe them was not independent of theory. Indeed, when we found that some kinds of families tend to seek treatment for neurotic symptoms in youngsters in the preadolescent age range, while others respond only to a major catastrophe, such as the neighbors' expressed intent to shoot the youngster on sight (Helson case), we looked to the Erikson developmental hypotheses and the Sullivanian developmental epochs for hypotheses about interpersonal concomitants of these behaviors. They suited our data very well. The study may be regarded as support for their hypotheses.

From records of cases most appropriate to each type, behavior descriptions appropriate to each category were written, and these paragraphs were compared with the rest on hand and with the

families studied during the third year's work. The description constitutes Chap. 4.

Table 7-2 is a list of the categories. An entry illustrative of the paragraph specifying the behavior for each syndrome under consideration appears under each heading.

Table 7-2.

RESEARCH OUTLINE FOR CLINICAL SUMMARY
AND SUPPORTING RATINGS *

	<i>Type</i>	<i>Pattern</i> (rating in kind)
NOMINAL PATIENT		
1. Syndromes		
<i>a.</i> in terms of arrest in development	A. Infantile functioning (schizophrenics) B. Childish functioning (autocrats) C. Juvenile functioning (intimidated) D. Preadolescent functioning (rebels)	
<i>b.</i> in terms of develop- mental tasks failed	A. Basic trust B. Autonomy C. Initiative vs. guilt D. Fear of intimacy and of establishing own identity	
<i>c.</i> in terms of endeavor substituted for de- velopmental task	A. Sympathetic symbiosis B. Infantile omnipotence C. Adult-value-centeredness D. Gang-value-centeredness	
2. Relationship with age- mates	A. Socially isolated, treats others as things B. Associates with peers only on his own terms C. With but not of his age-mates D. Relates on a basis of group membership; has many "friends" but no "chum"	
<i>a.</i> individuals		
<i>b.</i> group life	A. No group life B. Participates by acting out the destructive wish of the group C. Propitiates the leader, serves the group; often the "patsy" D. Seeks to diffuse own identity in the group	
3. Sex role in relation to parents	A. Neither seeks nor gains individuality from exploiting parent (Types A and B seem pre-Oedipal in that they do not differenti- ate what they want from parents according	

Table 7-2.

RESEARCH OUTLINE FOR CLINICAL SUMMARY
AND SUPPORTING RATINGS * (Continued)

Type	Pattern (rating in kind)
	to sex, but according to which parent is controlled)
	B. Nuisance value to both, more nagging with the mothering one
	C. Yearns for acceptance from parent of same sex who gives unclear model; fear of retaliation for closeness to parent of opposite sex yields behavior appropriate to latency
	D. Differential reaction to sex of parents appropriate to beginning heterosexual stage, e.g., girls provocative toward father
4. Sex role in relation to peers	A. Makes no sense to peers, autistic relationship
	B. Exploitative relations with younger or older youths; does not differentiate by sex
	C. Feels that he (she) does not measure up to the (exaggerated) standards perceived for own sex; heterosexual interest subdued
	D. Behavior with opposite sex ostentatious and designed to enhance reputation with own gang, caricature of age group
5. Attitude toward education	A. Educationally disinterested
	B. His project is to make the person fail who has goals for him
	C. Interrupted by manifest anxiety and associated symptoms but conscientious
	D. Well-informed but does not like to get caught showing interest in anything constructive
6. Attitude toward authority	A. Trouble with parents only—often reported "well-behaved" in school
	B. Oblivious to authority
	C. Intimidated by authority
	D. Fascinated by authority; gets in trouble in a way that guarantees being dealt with firmly and with interest
7. Anxiety	A. Manifested by schizophrenia

Table 7-2.

RESEARCH OUTLINE FOR CLINICAL SUMMARY
AND SUPPORTING RATINGS * (Continued)

Type	Pattern (rating in kind)
B.	Acts out, low frustration tolerance, guilt free, arrogant, impulsive
C.	"Stays with" large amounts or has rather obvious symptoms
D.	Tries to diffuse anxiety into the group; does not like to be caught showing any kind of concern; pseudo rebellion releases tension

INTRAFAMILIAL PATTERNS

8. Family constellation

- A. Deficiency of leadership and symbiosis; patient is often the effective leader
- B. Imbalance of leadership with collusion; patient controls through unpredictability
- C. Hostile, demanding leadership of competitive parents; patient, intimidated by parental quarrels, relates through symptom formation
- D. Husband figurehead, wife suppresses own overt leadership in a family of compromises; patient's pseudo rebellion requires control by others

Note: Each of these types of family constellation is expressed by locating family members on the Diagram of Constellation, Fig. 7-1. See also Figs. 4-1 to 4-4.

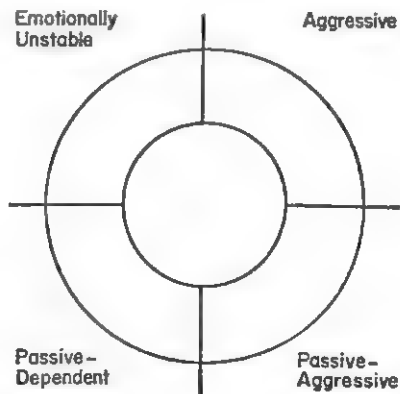


FIG. 7-1. Diagram of Constellation.

Table 7-2.

RESEARCH OUTLINE FOR CLINICAL SUMMARY
AND SUPPORTING RATINGS * (Continued)

Type	Pattern (rating in kind)
9. Sibling situation	<p>A. Nominal patient resigns privileges and refuses responsibilities of seniority; loss of "birthright" to more dependable sibling who may later show a different type of arrest</p> <p>B. Some loss of privileges by nominal patient to more dependent younger sibling who, however, tends to cling to passive-dependent position in the family</p> <p>C. Competition to avoid blame, intense sibling rivalry and, in the nominal patient, a "middle child" attitude</p> <p>D. Competition for privileges of irresponsible youngest and demand for privileges of oldest; rivalry sporadic, not intense</p>
10. Patterns of fatherhood and husbandship	<p>A. Participates in own exclusion and manifests instability in schizoid ways</p> <p>B. Reluctant to exercise authority in rearing the child; feels regarded by child as intruder, passive-aggressive</p> <p>C. Delegates maternal functions to wife, covertly vies for maternal role, covertly rival of children for wife's ministrations; dominant façade with underlying feelings of impotence</p> <p>D. Remote toward daughter after puberty; specializes as provider, exercises community leadership and dominance in formal aspects of home life</p>
11. Patterns of motherhood and as a spouse	<p>A. Infantilizes nominal patient; passive-aggressive toward rest of family</p> <p>B. Insult to individuality of child associated with disenchantment with symbiosis; aggressive</p> <p>C. Acts as older sibling, hired maid, tends toward rejection of nominal patient; passive-aggressive</p>

Table 7-2.

RESEARCH OUTLINE FOR CLINICAL SUMMARY
AND SUPPORTING RATINGS * (*Continued*)

Type	Pattern (rating in kind)
12. Exploitation	<p>D. Manipulates child to enhance relations with spouse, may compete with child for husband's favor, executive function in the home</p> <p>A. Mostly sought by needy parent</p> <p>B. Mostly sought by needy child</p> <p>C. Emotionally depriving—child exploits through neurotic symptom formation</p> <p>D. Uses child as a negative extension of self attempting to live through child by fostering achievement or unacceptable behavior in child</p>
13. Value transmission	<p>A. From mother—suppressed desire for narcissistic expression; from father—suppressed desire for dependency; from both—greatest discrepancy between overt and covert communication; child lives out mother's desire to do just as she pleases mixed with father's way of exemplifying "uniqueness"</p> <p>B. Imitates parent of same sex in caricature</p> <p>C. Fear of deprivation is transmitted; adolescent yearns for identification with parent who, however, sets unclear model; only symptoms are rewarded; unconscious desire to depend is conveyed by both parents</p> <p>D. Girl seeks experiences for which mother could only yearn; boy expresses mother's contempt for father's "goodness" by carelessness; unconscious desire of parents for aggressive expression is transmitted; the process is more clearly identification with parent</p>
14. Family response to crisis	<p>A. First response was toward extruding nominal patient or having him specially labeled as hopeless</p> <p>B. First response was to seek help in curbing child's behavior to maintain the <i>status quo</i> otherwise</p>

Table 7-2.

RESEARCH OUTLINE FOR CLINICAL SUMMARY
AND SUPPORTING RATINGS * (Continued)

Type	Pattern (rating in kind)
	C. Relief of symptoms and preservation of marriage sought
	D. Mobilization of family to contain rebellious member
15. Attitude (particularly toward therapy)	A. Initial resistiveness high, resolving toward dependency
	B. Initial resistiveness high, resolving into cooperation
	C. Initial cooperativeness high, resolving into dependency
	D. Youth: verbal-defiant; father: cooperative-detached; mother: resistive-guilty
16. Community relations	A. Isolated; father may have dependent relation with relatives, boss, or cronies
	B. Mother deficient in community-relatedness
	C. Mother gives history of community-relatedness interrupted by marriage; father has limited and inflexible ways of relating to community
	D. Involved socially and officially; upward social mobility a goal
17. Communicative style	A. Obscure, oblique, insidious, double-binding
	B. Double-bind communications with the mothering one; other parent's comments are disqualified
	C. Excesses of verbal communication; father shows aggressive façade; mother throws up smoke screen; competitive relations between parents supplant tender ones
	D. Overt competition outside home only; speaking is for public, not private situation; nothing "really important" discussed at home; acting out more effective for youngster than persuasion

* Each item on the left should also be rated with respect to *Intensity* on a scale from 1 (low) to 5 (high).

Psychological Test Data

Psychometric patterns in the Wechsler-Bellevue clearly distinguished two groups: one that externalized aggression, including all the rebels and the autocrats (Types D and B), and one that internalized aggression, the intimidated youth (Type C).

All of the autocrats and many of the rebels were described in psychological reports as having an antilearning attitude. Verbal scores of these youths, who are prone to act out, reflected their poor fund of knowledge in contrast with their learning ability. Their performance scores were relatively high, especially in matters involving the motives of people, and significantly lower in matters of speed and accuracy. The data were that block design and digit-symbol subtests, while higher than verbal test scores, were lower than scores on the picture arrangement subtest of the Wechsler-Bellevue. The influence of anxiety, demonstrated on Rorschach's test, was handicapping for the rebels but not for the autocrats, and was believed to account for significantly lower scores of the rebels on arithmetic and similarity tests.

The intimidated youth, in a manner typical of their adult-value-centeredness, showed more effects of civilizing forces in their better scores in matters testing fund of knowledge, and in speed and accuracy. Rorschach's test found them to be the least imaginative, and both tests found they had poor insight into social situations. Verbal scores were higher than performance scores. These youngsters were awkward socially and mechanically.

The test results on the six schizophrenic adolescents were few, and they varied with the examiner's skill at eliciting responses from the youths.

Retest results, like other re-evaluation procedures, tended to confirm patterns. Factors of increased cooperativeness and being tested at home made the retest results difficult to interpret except for the general confirmation that growth was accelerated and that the typology received further confirmation.

Categories in Relation to Therapeutic Change

Rerating families at follow-up under each of these categories showed not movement from type to type but movement toward flexible functioning. The team judged the pattern to have decreased or increased in remoteness from an optimal state of affairs. For example, the autocrat did not become fascinated with authority but did not remain oblivious to it. Therapeutic change in families not only was characterized by movement in particular categories of living but generally appeared to be a move from a relatively closed system, where one change is compensated by another, to a relatively open system, where increased creative response to influence from outside the system results in growth.

In summary, at follow-up we were able to confirm or revise our impressions about the family diagnosis. We knew the families better and now could see their functioning in depth. On the whole, the diagnostic types still held at follow-up, but where therapeutic intervention had been effective the whole family operation had moved in the direction of adaptability.

RESULTS OF THERAPY

The initial objective of this therapy is not necessarily, as the parents of many adolescents request, to move the child from an extreme position in order to allow the parents to relax, but to deal with the parental interaction which forces extreme behavior on the youth. In Chap. 5 movement was described in terms of the approach to an initial objective, because when the initial objective was not accomplished, the outcome was not successful. Parental interaction was therefore a primary object of evaluation at follow-up, in addition to changes in adjustment under the various categories of the outline.

The following section is a report on the favorable outcome of 49 cases and the unfavorable outcome of 13 cases. In each case with a favorable outcome, progress in family rehabilitation was associated with or followed by improvement in the nominal patient, fairly

rapid in 38 cases, slower in 11 cases. The latter group includes all the families of the six schizophrenic adolescents (see Table 7-3). With reference to most of the headings under which our families were studied, there was in the successful cases a diminution in degree of remoteness from optimal functioning within the type rather than a change toward another type. (The only exceptions were four of the autocrats who moved from childish to juvenile or preadolescent functioning.)

Table 7-3.

RESULTS OF THERAPY

Type of family	A	B	C	D	Totals
Favorable outcome					
Improvement in nominal patient	0	10	14	14	38
Slower improvement in nominal patient . . (patient in intensive individual therapy)	6	4 (1)	0	1 (1)	11
Number of cases in each group	6	14	14	15	49
Unfavorable outcome					
Failed to mobilize family self-rehabilitation	0	8	0	3	11
Family improved but adolescent was not part of home at the time	0	0	0	2	2
Number of cases in each group	0	8	0	5	13
Total cases, favorable and unfavorable . . .	6	22	14	20	62

The Six Schizophrenic Adolescents

These six cases serve only to indicate the way in which our work may be related to that of others, such as Bowen [3], who have made great strides in showing the therapeutically relevant family dynamics of schizophrenia. More time is necessary to evaluate the durability of changes in the schizophrenics and their families. All were seriously handicapped youths for whom a much longer time will be needed to know whether their rate of growth is sufficient to meet the new developmental tasks that naturally present themselves to these young people accustomed to disqualifying themselves from life's challenge.

Five of the six schizophrenic youths have resumed interest in educational programs and have apparently made sufficient progress so that they are in competitive status with their age-mates. At latest follow-up, two were in school and three had completed basic military training. All of the mothers were able to redirect their activities in a sufficiently enduring way so that there is little likelihood that the exploitative pattern will be resumed with the nominal patient or sibling. While only one of the schizoid husbands showed markedly constructive personality change (Milton), the family constellation in another four is such that there is more room for the father to express his pathological condition. Retest of Bonnie Birge's father at 6 months follow-up showed him to have increased feelings of impotence. At 18 months follow-up we learned that he had died in an accident.

The Autocrats

The families presenting childish functioning in an adolescent (Type B) are considered the most significant group of successful cases. This is true despite failure in eight cases and very slow improvement in four more (see Table 7-3). These are the families with which other methods have had little success. In other settings these youths would have been diagnosed as having character disorders. In half of our series, the adolescent tested the new balance of leadership in the home and found it firm and accepting. These 11 youths turned their efforts from a dedication to maintaining childish omnipotence to furthering their educational, social, and occupational growth. Each displayed ability to take initiative and to accept the associated responsibilities and limitations. They showed a capacity for intimacy without excessive recourse to gang identification. They found acceptance among age-mates of both sexes. They did not move into difficulty at the successive developmental levels. When such a family moves into the area of creativity in its division of functions, it appears that despite failure of the youth to have spent the usual time at tasks of the succeeding de-

velopment epochs, he meets their challenge and enjoys solving the problems.

With 3 of the 22 adolescents of this type, the change was judged to be from arrest at childhood to arrest at preadolescence, both in the nature of the rebellious behavior and in the nominal patient's relationship to the family constellation. This kind of limited improvement occurred where the inadequacy of the father was so marked, and his changed role in the family was so heavily sponsored by his wife and the rest of the family, that he seemed to move from dishonored exclusion to the pedestaled exclusion we have described for the father of the rebel. It occurred in the Marvin family, where the father was not living but the mother became able to mourn her loss. The changes in the youngster indicated some durable improvement in that the developmental tasks of preadolescence were performed. Thus, solitary acting out was replaced by participation in gang behavior. The yearning for strong guidance from authority was seen in the way he began to test its limits and his own limits.

The change from childish functioning to preadolescent functioning in adolescence is illustrated by Henry Linton.

When the Linton family participated in MIT procedures, the characteristics of the autocrat were clearly evident. The chief complaint of "high temper" was related to Henry's inability to recognize or admit any limitations on his behavior, and to his violent rage reactions to efforts by parents, school, or community authorities to enforce conformity to existing laws and customs. At the age of 16 he drank to excess, had been expelled from school, and was isolated from age-mates; his only companions were several delinquent youths considerably older than himself.

In a way typical of the autocrat's family, the father had long since "given up" any effort to be influential at home, and responded with passive resistance to his wife's belated effort to "delegate" some parental authority to him. His son's interest in hot rods and racing was clearly a caricature of the father's skill and pride in motor maintenance and repair.

Follow-up visits to the home 9 months and 18 months later revealed a gradual but marked shift in family balance. The parents supported

each other in enforcing standards for Henry's conduct at home, and after staying with relatives across the street for several weeks, Henry returned home at his own request. Evidence of his increased respect for parental authority included his sweeping up and removing fragments of a glass thrown in anger, rather than fighting or running, which had been his habitual responses to suggestions that he repair damage he had caused.

The father's increasing prestige and influence in the family was enhanced by his leaving a job he had held for many years and going into business for himself. Henry worked for his father for a while but quit in anger and was replaced by another "helper" in the shop. In a time of scarce employment, Henry at the age of 17, faced the choice of idleness without spending money, or school attendance, or military service. He chose to return to school, where he was accepted on condition of regular attendance, reasonable effort, and conformity to school regulations. He began to associate with classmates, he frequented the malt shop instead of the bootlegger, and his dating pattern changed to thoughtful efforts to entertain and please a girl rather than the arrogant "showing off" of his earlier dates.

In eight cases, the initial objective of modifying parental interaction was not achieved. Seven of these youths progressed in an increasingly psychopathic and one in a schizophrenic direction. These eight families may be similar to the "egocentric family" described by Voiland and Buell [4]. Throughout the period of study, the parents in each of these eight families persisted in seeking to subvert the team's efforts toward mobilizing family rehabilitation and to substitute a short-range goal. The parents continued to cling to their original request, that the team somehow remove or reduce a particular symptom of the nominal patient, such as stealing, temper tantrums, or other embarrassing behavior, without otherwise altering the *status quo*.

In seven of these eight cases, at least one of the parents was frankly and consciously dishonest with the spouse, the offspring, the team, or authority and society. One father persisted in his demand that the team notify the school authorities that his son was medically unable to attend school, although he himself concurred with the team's opinion that this was not so. One mother refused

her son's request that she bribe the juvenile judge to dismiss charges against him. To her son and to the team she explained her reasons: her husband would not agree, and the judge would not accept the bribe. Another father gave his son the keys to the family car and permission to use it, and later told his wife that the boy had stolen the keys and the car. This same father attached a hidden tape-recording mechanism to the family telephone in order to eavesdrop on his son's phone calls.

One obvious, but perhaps naïve, conclusion might be that the unfavorable outcome of these cases resulted from the dishonesty and lack of motivation in the family. However, another factor should not be ignored, and that is the team's reaction to the unacceptable attitudes and behavior of these parents, and also to the parents themselves. Strongly imbued with conventional middle-class standards of integrity, team members were sometimes shocked or horrified by gross dishonesty on the part of the parents. They had some difficulty in regarding such parental attitudes and behavior as symptoms, and in handling or concealing their own negative reactions. Since the interaction between team and family is considered an important factor in the therapy, it is reasonable to suppose that this interaction is equally important when the therapeutic endeavor is unsuccessful. The eighth case with an unfavorable outcome seems to reinforce this conclusion. Here, the parents were not overtly dishonest, but the mother was an extremely immature, narcissistic young woman. The case record reports that she was "disconcertingly seductive toward male members of the MIT team." This seemed to account at least in part for the team's failure to recognize soon enough the nature and extent of the family's pathological condition.

The Intimidated Youth

All 14 of the families presenting juvenile functioning in adolescence in the nominal patient have shown, as we have indicated, satisfactory progress. Our sample is small, but presentation of these data is useful to show again how our work relates to an area al-

ready well explored. This type seems representative of childhood neuroses as usually seen in child guidance clinics. Our results indicate that MIT is suited to this group. Other clinics which have used the method have found MIT particularly useful with the families of this type where there was a long-standing chronic situation and an absence of current crisis. Almost every month the present intake team in the Division of Child Psychiatry at the Medical Branch, who are of course familiar with the method, reach the point of saying, "We are not getting this family into treatment by usual methods, let's try MIT."

The intimidated youth became free of their neurotic tendency toward symptom formation but at differing rates, as the parents became aware of the meaning of the symptoms as distress signals and responded with tolerance. This seemed to reduce the tensions formerly augmented by the symptoms. In most cases, this reduction of tension followed the youth's becoming a significant party to a family project.

Mrs. Craven's shy, overly dependent daughters rallied around her effort to establish a new home apart from the grandmother. Each had meaningful chores, and their new feelings of significance and identification with mother's vigorous efforts were reflected in improved schoolwork, where formerly the girls and their mother had seemed too ill and needy of the grandmother's care to permit regular school attendance.

The Gaspard family united in a project of running a local shopping newssheet which the boys delivered.

The Heyman family, racked by the cultural conflicts of a Mexican-Protestant-Jewish background in a border town, enrolled in the educational projects of the growing local synagogue. They enjoyed learning to be Jews under the father's leadership.

In each case the dynamics of the change in the adolescent seemed related to the clarification of the role of the parent of the same sex. Specifically, these youngsters yearned for leadership with which they could identify. Their antisocial behavior, when it occurred, had as its goal the winning of a leader's approval. When

clearer models for identification and stronger cooperative leadership were provided by parents, the need for seeking leadership and approval outside the home was reduced. In the cases of boys, when they were accepted by their fathers as participants in a family project rather than rivals for mothering attentions, the Oedipal tension was relaxed. Mothers who had previously been excessively the objects of their husbands' temper tantrums tried cooperating instead of competing with their husbands. This released the husband from having to defend an overextended position tantamount to a claim to autocracy, and from the need to prove himself in just those areas where he felt most inadequate. The consequences for the adolescent were such that he could take initiative in matters of self-interest in the masculine world without the gnawing fear that Father would be threatened by his winning Mother's approval. Whereas previously these youths had confined their efforts at gaining security to serving Mother in their school homework and in the household work, they became able to gain Father's respect for interests he could recognize as similar to his own.

Walter Tone was referred for extreme nervousness. This appeared to be mostly a kind of panicky behavior he exhibited, much to his father's disgust, whenever he was called on to participate with his father in some of the manly chores about the farm. On one occasion Walter alarmed the family by turning with anger toward his younger brother while holding a knife that he was to use as a part of routine butchering.

This is the third marriage for Mrs. Tone, a part-time cleaning woman. Her husband is a semiskilled maintenance worker for the local schools; he also manages and operates a small farm of which he is part owner. A considerable part of the tension in the family grew out of parental conflict. The father expected and required the boys to do various farm chores, and the mother contested his requirements by asserting that the boys should spend more time in schoolwork assignments, making school her project. Walter responded by diminished school participation and a request to transfer to a rural school near the grandparents' farm.

This was an acute situation which responded to one-day procedure with two follow-up sessions at monthly intervals.

On the first follow-up visit, Mrs. Tone expressed her pleasure with

and understanding of the route to improvement by saying discreetly and in an aside to one of the team, "I got the message and bought myself a filmy negligee." When Mrs. Tone became aware of the way she had made her affection more accessible to her sons than to her husband, and when she ceased to make the boys' schoolwork her project, Walter began to show at home some of the farming skills and interest he had shown previously only on his grandparents' farm.

At the second follow-up visit she told us of her own response to Walter's expressed plan to spend his summer's earnings on clothes for her. She recognized the unwholesome significance of her son's gesture, and expressed to him her satisfaction with her husband's care and judgment. Here, it was the mother's ability to communicate to her son what she liked about her husband, instead of nursing her complaint that Mr. Tone treated her with little respect, that freed the boy to identify with father. Not only were the marital discord and family tension reduced, but the father took considerable interest in encouraging Walter to develop a project in the 4-H Club, with which previously the boy had only nominal participation.

The change in the families who presented juvenile functioning in an adolescent nominal patient could be diagrammed for the fathers on the chart as movement from the extreme of both the aggressive and the unstable positions, a movement from autocracy and control by temper tantrums into a more flexible area of the aggressive quadrant. For the mothers it was a movement from the role of the passive-aggressive "trapper" into the role of a constructive critic, a normal feminine role in homes having masculine leadership. For the youth it was a movement from intimidation in the passive-dependent position into the center area that allows growth. The youth was freed from excessive anxiety so that he could take pride in his developing identity as an individual.

The Rebels

In 17 of the 20 cases presenting preadolescent functioning in adolescence, there was substantial movement in family rehabilitation. Only 15, however, can be considered to have favorable outcome.

Of the cases with favorable outcome, the results were varied.

For example, in one family the mother entered group therapy in her home community, and in another both mother and daughter continued individual therapy after MIT. Six of the older adolescent patients achieved emancipation and left the family, four to join military service and two to be married. Follow-up reports one to two years after MIT indicated satisfactory adjustment for all six young people in these adult roles. Of the four young men in military service, one had continued to receive extensive counseling from the probation officer who referred him. Before her marriage, one girl had developed a good relationship with the medical doctor who treated her for a gynecological condition and who also counseled her in matters relating to acceptable moral and social standards as well as personal hygiene and protection of health.

In two cases, the youth left the self-rehabilitating family unit less than a month after MIT; one moved into the home of female relatives who were themselves inadequate and poorly adjusted, and the other became economically self-sufficient. Within a few months each had associated himself with a homosexual group in his community.

Of the three cases in which rehabilitation processes were not mobilized, one had never been a stable family unit; the mother had had numerous liaisons, and the nominal patient had lived in institutions and foster homes, and only intermittently with her mother or with relatives. It is clear in retrospect that this family was not sufficiently intact to justify an attempt at family therapy.

The 20 families presenting preadolescent functioning in an adolescent are representative of those most usually dealt with in literature about teen-age problems. With the 15 families having a favorable outcome, it is difficult to say whether the variety of therapeutic approaches utilized were successful or whether time just ran out on the youngster's ability to delay emancipation. Perhaps our major contribution was to separate them diagnostically from the childish group, who also flagrantly act out in antisocial ways. These young people were not on the verge of severe mental illness, but they were on the verge of coming to grief in their re-

lations to society. The problem was not so much one of helping them to live with their families as it was one of preparing adolescents and their families for emancipation. The initial objective was to mobilize these families so that in the months immediately following MIT, the family would have a maximal opportunity to transmit more effectively to the youth those values of their culture which would enable the youth to exemplify its goals independently.

The route to accomplishing this objective seemed to require the parents to set firm but broad limits on the adolescent's behavior, with the clear understanding that he would assume increasing responsibility and privileges as quickly as he demonstrated ability and willingness to accept them. The parents' respect for the offspring as an individual, capable of learning to function independently, without parental support or restraint, provides an atmosphere conducive to establishing a consulting relationship between the youth and his parents.

Linda Tague, who seemed to have the task of living out the unexpressed flirtatiousness of her mother, responded with appreciation when her parents enforced rules against her being in unsupervised situations with boys. The bravado of her acting out gave way and she was able to establish solid friendships with the girls her age. Previously she had only been able to pretend having friends by going back to a school district across town to see her playmates of earlier life. Her identity had been obscured by her reputation for promiscuity which was more apparent than real. When her mother desisted from the patronizing attitude toward her husband, an attitude which made it difficult for Linda to accept him as an authority in the home, Mr. Tague was able to take a more active part in enforcing limits on his daughter's irresponsible but precocious behavior. The doubt about the distance between the generation of daughter and that of father no longer required her rebellious behavior to remind him he is authority, not competitor or object. At 18 months follow-up, instead of annoyance with the privileges of her younger brothers, she showed toward them much more the pedagogic attitude of her schoolteacher mother.

While Mrs. Pettis behaved as though artificially building her husband's morale was the central problem in holding the family together, her daughter Carolyn appeared compelled to reveal the implied weak-

ness in her father by defiance of his authority and exposure of the "no good" aspect of herself. After family therapy the mother was able to respond to the real worth of her family members. She had relinquished the governing of the unruly and promiscuous behavior of her daughter to a probation officer whose general rule was to restrict the girl to quarters. When her daughter tried again to have her mother make decisions, Mrs. Pettis rose to the occasion by deciding in favor of allowing Carolyn to go out on a date with an apparently reliable young man. The trust that developed between the mother and daughter allowed them to discuss Carolyn's problem. Carolyn was able to see that the improvident picture she had of her father was based on her mother's overreaction to previous misfortune. As the mother became more accepting of her husband's way of recovering the family fortune, he had less need to provide the family with pretentious facilities beyond his income. Instead of the objective of winning back his daughters by building them a swimming pool, he turned his efforts to occupational interest which had begun to receive more significant recognition from his wife. While he continued to grumble disapprovingly about his daughter's behavior, he made it clear that all this was probably understandable to the womenfolk in the home whose judgment he now respected. Two years later, as a wife, Carolyn consulted us about a problem of helping her husband and her parents bear up under some bad news. She easily saw that she, like her mother, was expecting weakness from the man of whose strength she was really fond. So she let her husband help share her grief over finding herself unable to conceive.

The youths after treatment had less fear of showing interest in adult-sanctioned matters. They were busy in work with adults that involved accepting responsibility and becoming known as individuals. There appeared to be a maturing of the capacity for intimacy. Durable relationships had developed with chums and sweethearts. Rebellion in most cases had given way to more comfortable ways of communication.

DISCUSSION OF RESULTS

While not representative of all families with adolescents, the way in which selective factors were kept to a minimum in the cases accepted for treatment with multiple impact therapy assured a suf-

ficient number and variety to compare the method with established treatment methods.

MIT as a Way to Family Self-rehabilitation

The type of movement noted was generally in the hypothesized direction of movement from stereotyped balance-of-power family relations, which induced arrest in development by forcing each family member to continue excessively in a single role, to a more flexible interaction that allowed growth changes for all members.

We described the initial situation of the families under 17 headings. Within each of these headings we discovered different characteristics for each of the four types of families. These characteristics of family syndromes provided a substantial etiology for the four developmental diagnoses of the youths. The change with therapeutic movement was found to be not usually from type to type but in the direction of an increased flexibility within most of the patterns described in Table 7-2. Thus at follow-up it was possible to confirm both the typology and the movement by restudy of the data in terms of the research outline.

In many respects the description of the project has been the most difficult task. We were not ready to settle for naïve columns of "cures" and "failures" in terms of criteria about which there was little agreement. We have built some verbal and conceptual bridges in terms of which the process of this therapy and perhaps others may be related to the presenting situation and to the outcome.

The first bridge is over the chasm of diagnosis. It is a rough bridge of four planks, but they are in a developmental sequence. Holding these planks in place, as in an arrest of development, are family ties. We observed a pattern of family relationships, a family diagnosis, associated with each of the levels of arrest in development of the referred adolescent patients. The diagnoses of families of those presenting infantile, childish, juvenile, or preadolescent functioning in an adolescent are shown to be descriptive of critical problems from which the families are seeking relief and, at the other end of the bridge, the diagnoses constitute job descriptions

of the therapeutic tasks to which MIT is addressed. Thus for pathological family interactions which result in arrest in psychosocial development, we submit a therapy which has as its initial objective the freeing of stalemated growth processes.

Graphic representation of the family constellation on a chart provides the framework for the next bridge, a bridge over which therapy passes from a statement of what is wrong with the family to a more promising situation described as the initial objective of this therapy. This objective is viewed theoretically as a movement away from extreme and inflexible functioning in a limited area to increased ability to function in other areas. It was hypothesized that such an increase in adaptability would be associated with the freeing of the youth and others in the family to proceed in their development.

We have indicated a goal of enhancing family self-rehabilitative processes, a goal that includes harnessing some of what has long been written off as part of spontaneous remission. A major aspect of this has been conceived somewhat as Bell [5] has seen it, as a change in a balance of forces in the family. We have observed that the improved relationship resulted in the movement of family members away from overly specialized functioning. The extreme position of one parent tends to force others toward extremes. Extreme positions in this study are operationally defined as a limited ability to take or understand other than a narrow set of attitudes. Thus the hypothesis is that movement away from extreme functioning in one area is associated with increased ability to function in other areas—to take or understand other attitudes. This is regarded as increased flexibility which makes possible the adaptability appropriate to growth. Diagrammatically this major aspect of movement in family living may be illustrated for an individual as movement from an extreme position with respect to a set of bipolar attitudes presented as a circle (Figs. 4-1 to 4-4). Movement from an unhealthy toward a more healthy state of affairs is also associated with increased ability to function in other areas. For simplicity, location in the central circle implies the ability of the in-

dividual shown to function in ways appropriate to any quadrant. It is the extent to which the individual functions in ways diagrammed in the center area that attitudes are sufficiently relaxed to function in an open system that admits mature growth experiences. The division-of-labor frame of reference, the balance of forces, and the emotional economy of scarcity are hypothesized to prevail only outside the center circle. The concept of homeostasis as used by Jackson and his associates [6] is useful for understanding what we call "the approach to the initial objective" but it is too mechanistic to account for growth in an open system.

The diagrams do not imply precisely measurable units, nor do they imply that all persons have equal influence. The influence of family members on each other is assumed to correspond roughly to some developmental standards reinforced by the culture. Thus, normally, parents have more influence than their children. Influence of indwelling grandparents, as Florence Kluckhohn [7] has observed, differs in lineal (e.g., Spanish-American) versus collateral (e.g., Italian-American) family cultural influences.

The present project, while not large enough to be more than exploratory, and while limited to relatively intact family situations, may have the advantage of having been somewhat explicit in its description of the initial position, the desired changes, the processes leading to change, the hypothesized forces involved in psychiatrically healthy and unhealthy situations, and the types of patients to which the findings apply.

The movement we have described, then, is regarded as significant because we were able to report a path to a position at which healthy human processes take over constructively, and to report that our interventions were associated with subsequent movement. The result was shown with sufficient regularity and in a sufficiently diversified population of families to indicate that this was probably not a chance happening.

Confirmation that MIT is a procedure to be considered particularly with more serious family problems comes from the favorable results with the infantile and childish youths and their families.

These are the kinds of families for which the fewest treatment approaches exist. The autocrats in particular account for a large portion of youths who act out antisocial tendencies but whose motivation for doing so is foreign to most current delinquency control methods. Where the approach to the initial objective was successful, the motivation of the more immature types seemed to become more appropriate to resources available in society for helping growth through preadolescence and adolescence.

The theory of movement from closed to open system functioning was accepted as an explanatory conception when we found that change was not usually from one developmental arrest to another, but that therapeutic change seemed to be a general resumption of growth processes.

The team's part in the therapeutic work, it was found, could be concentrated into three days with occasional follow-up. The shortness of the period is possible because the attention is given almost entirely to interpersonal processes with content used only in an illustrative way. The capacity for insight, spontaneity, and growth is enhanced, but the use of insight therapy is necessary only at critical points to free stalemated interpersonal processes. Brevity is also possible because of the cumulative impact of evidence and the convergence on dynamic themes related to constructive course of action. The therapy differs from other psychotherapies in that it does not ordinarily proceed in content through the analysis of successive developmental stages. It frees the family to handle these developmental processes in natural ways.

MIT as a Way of Clinical Investigation

The clinical research team found it could give detailed specification to the several syndromes described in Chap. 4 because of the intimacy of participation with families afforded by the multiple interactions involved in this therapy. The associated developmental diagnoses of the adolescent patients have made it possible to import directly into psychotherapy many usual and well-substantiated techniques of normal child rearing. For example, there are some

differences of opinion in therapy about whether it helps an adolescent to relieve him from decision making. This is precisely where the developmental diagnoses are useful. In the cases of the rebels it is not therapeutic to accommodate them by diminishing responsibilities, whereas for the autocrats, whose childish functioning in adolescence also takes defiant forms, it is therapeutic. Another issue: when is it a good idea to favor rebellion? Not with the rebels. The goal of their rebellion is not emancipation but accentuating the separation between generations. They were made anxious by the occasional therapist who regarded their rebellion favorably as a sign of increased maturity [8].

It might be worthwhile to study a delinquent population in terms of such developmental diagnoses. It would seem that the associated influence of broken homes and massive deprivation would forecast a finding of fewer rebels. Less adequate homes would be expected to yield more children arrested at a childish level of development. Such a study would have implication for youth-serving agencies because their programs are presently slanted toward the appeals of group life, leadership, and responsibility, all of which tap interests developmentally more adolescent. The impression that rebels are more prevalent may be because their rebellious behavior makes more sense to adults and is not easily differentiated from other antisocial behavior.

In the experience of delinquency-prone youth the rebels may provide the ingredient in locker-room talk that stimulates the mixed bravado and fear of heterosexual relations of the more neurotic, juvenile youth. Actually, if something really rewarding were going on with a sweetheart, as it may be with the truly adolescent youngster, he would be more discreet. It may be that in the structure of street gangs there are a few leaders of this preadolescent type, aided by lieutenants of the juvenile type who do the dirty work in order to propitiate these leaders, and that together they exploit the cruelty and violence which can be triggered in the still more unstable childish group. It seems that blighted areas and

broken homes should produce more of the autocrats, although most of the group-work literature seems aimed at appealing to the fascination with authority of the rebellious group manifesting pre-adolescent functioning in adolescence, who are possibly much less significant numerically.

The special entrée into family life enjoyed by the team made possible discoveries which converge with current developments in psychiatric theory. For example, responding to theories of Erich Fromm, we were disposed to look for disguise of tenderness and vulnerable growth processes instead of repressed knavishness and taboo thoughts. We found problems *presented* by families in terms of competition and aggressive behavior when the *real* problems had to do with inferiority feelings associated with stalemated growth processes and collusion to avoid competition. Fromm [9] shows that guilt feelings are more likely to be associated with the feeling of inner emptiness that comes from failure to develop with life's opportunities than with sins of commission.

Fromm observed that in our society of decreasing capacity for intimacy, tenderness and spontaneity are more often repressed than sexuality and harshness. Tenderness and trust have been culturally associated with weakness. The mechanism which obscures discovery in family dynamics is the collusion that occurs where tenderness and trust must go underground just as repression, until Freud, obscured discovery in individual dynamics. Typically, the form in which we found sibling rivalry and Oedipal competition was that of collusion to hide weakness.

In the relatively closed system of the family in its defensive structure we discovered attitudes appropriate to what Ernest Schachtel [10] describes as *embeddedness-affect* in his work on human development entitled *Metamorphosis*. The attitude appropriate to growth, a relatively open system, he terms *activity-affect*. In that study Schachtel shows most current theories, including Freud's, to be based on a *conflict* theory of affects. Conflict theory, he says, assumes that activity with the drive object dissi-

pates the drive and diminishes affect. Our observations too confirm the notion that encounter instead of a "letting off of steam" stimulates growth processes.

New discovery is possible when we look again for what is repressed. Freud showed how in normal development available energy is increased as short-run satisfaction of instincts is suppressed. Later theorists have shown that in neurotic or defensive situations what is believed to be vulnerable is hidden. Thus tenderness, curiosity, and willingness to collaborate are often hidden behind masks of strength—harshness, dogmatism, and competitiveness. Family therapy allows the clinical team direct participation in some of the more tender processes.

MIT as a Way of Training and Supervision

The effect of MIT on communication within the team is not unlike the effect on families. When we found ourselves overly competitive with each other before the family, in addition to bringing out the way the family incited our own competitiveness, we resolved—sometimes in the family's presence—problems of respecting each other. This had favorable consequences for our ability to continue in collaboration over several years and for the team's ability to accept the emancipation of one of its members into private practice. On a number of occasions this member, Dr. Schuster, has enlisted a social worker and a psychologist from his community to use MIT as a private practice procedure.

A psychiatrist visiting from a distant clinic where he had recently become the director was particularly interested in the way the method induced newly added members to resolve difficulties in relating to colleagues differing in experience and seniority. He reported to the Southern Regional Education Board [11], which sponsored his visit and the visits of a number of others, that when the technique is used in his clinic there is astonishment that so much is learned so quickly about the family. He also commented that the use of the method in his clinic "has contributed a great deal to the development of our less experienced staff and our social

work students who are here on field placement. There is much less defensiveness on their part in regard to the work they are doing and its supervision."

The usefulness of exposure of students to MIT to augment training of the medical students and psychotherapists in family dynamics and in psychotherapy at our medical school has received some confirmation from the experience of other medical training centers and a school of social work where the materials incorporated in this book were used in conjunction with the tape recordings by instructors who had visited the Project.

Other Applications and Implications

We find that the method need not be restricted to outpatient psychiatric clinics. Our quarters have been moved to a hospital setting where occasionally the nominal patient or a parent was seen as an inpatient with the rest of the family participating, and the team's principal members included the ward doctor and the referring psychiatrist. On two occasions the nominal patient was brought directly from the state training school, one as a part of institutional discharge procedure, and the other with his family early in his period of institutionalization. With the latter adolescent, Scott Glamis, we were able to have a favorable influence on the youth's adjustment in the training school and to help the school, by a diagnostic study, in stressing aspects of their program most suited to the youth. Such experiences have led the team to embark on another demonstration project exclusively with delinquent youth to explore further the use of diagnostic aspects of MIT in developing recommendations to youth serving agencies.

Variations of the method have been employed by the Project team and by others who have studied with the team in a variety of settings in addition to community mental health clinics. A family was seen in an adolescent ward of a state hospital by a team consisting largely of hospital personnel. The Wiltwyck School for Boys, a residential treatment center, reported to the National Institute of Mental Health [12] use for over a year and a half of an adapta-

tion of MIT using staff *in loco parentis* to augment the family, particularly in broken home situations. Drs. Serrano and Wilson [13] have described the use of MIT in the treatment of the brain-damaged child.

A social work director in a county health department in Georgia, working with the problem of a family badly shaken by the fact that the adolescent son, age 18, was charged with a serious crime, consulted with his psychiatric director and drew together a team of people from a number of agencies involved in the case to work for two days with the adolescent and his family. The team consisted of the visiting teacher, a public health nurse, a consultant in mental health nursing from a state agency, the social worker, and the psychologist from the child guidance center. The social worker reported improved interagency functioning as a result of their work together in addition to the family's improved ability to withstand the crisis in their small community.

The trend in family service agencies toward dealing with families rather than individual clients suggests that they might well consider this method. The frequency of invitations for the several family therapy projects to present their material before professional social work societies indicates that social workers are actively considering the approach implied by family therapy. There appears to be a similar trend in the curricula in pastoral theology and pastoral counseling offered in medical centers and divinity schools.

Future work with the typology of families may well solve the problem of terminology in interpersonal situations. At present our titles are cumbersome, e.g., "families presenting childish functioning in adolescence, the autocrats." To refer to this type simply as "collusive families" would be to refer to a datum rather than the findings of this study. Interdisciplinary teams collaborating with families may find through our methods and their own a more definitive set of family diagnoses.



APPENDIX A

The Dyal Family, A Two-hour Intake: Description, Typescript, Formulation, and Follow-up

Because of its value as a diagnostic procedure and, at times, as a definitive step in mobilizing family self-rehabilitative processes, a summary and the proceedings of a team-family intake interview are presented below. The session consisted of three 40-minute interviews in a continuous two-hour period.

The Dyal family were unable to prevent their 16-year-old daughter, Sally, from running away to be in the company of irresponsible boys. Lies she told others about her family led her mother to doubt the girl's grasp of reality. She had reported a nearby cousin killed, when actually he had escaped injury in an accident. She had circulated a story that she was her father's illegitimate daughter. The mother was also impressed by the intricacy of fabricated detail that supported the stories. Concern for Sally's mental health caused Mrs. Dyal to bring her daughter from their 100-mile distant village to Galveston in hope of finding help. Friends arranged an emergency appointment with a hospital psychiatrist who referred them by a letter containing the following information.

The mother complained that Sally had been behaving in a somewhat delinquent manner for about two years. Sally was depressed and cried almost constantly throughout the interview. The psychiatrist's diagnosis was "a behavioral disorder, either on the basis of a sociopathic personality or neurotic acting out based on unusual family relationships." He referred Sally and her parents to the Youth Development Project "because more than one member of the family needed treatment." The intake interviews reported below occurred two weeks later.

For the first 40 minutes, mother, father, and daughter were seen together by the basic team. Mrs. Dyal was a tired-looking, earnest, intensely concerned woman of 37 years. Her husband seemed robust, despite a slight limp, uneducated, and ill at ease with professional people. Sally, tall and pretty, was subdued but obviously smoldering with rebellion. It occurred to various team members that she might also feel ashamed of her parents' humble appearance and attitude. Mrs. Dyal complained of her daughter's lying. The psychologist asked Sally what made her parents difficult to be honest with. The girl, after a period of hesitancy, complained that they were too restrictive. Her father seemed to try to answer the question for her by recalling aloud that at Sally's age he had resented his family. As he talked, he seemed to discover that he had always taken undue advantage of his own parents' readiness to indulge him, whom they considered crippled. He explained that because of his irregular schedule as a towboat captain he had too little opportunity for relaxed companionship with his family. The mother responded competitively noting that her own long period of illness, kidney difficulties following pregnancy, and a background of rheumatic heart disease, had made her and her husband intolerant of their daughter's complaints. In tears, she said her own preoccupation with her trouble kept her from an awareness of her daughter's troubles. The family agreed that this was the first time they had been able to get these things said in each other's presence.

The psychiatrist on the team pointed out that much of father's intolerance stemmed from an attitude of which the father was

unaware: that his daughter should undo *his* past mistakes. Knowing little about his past and nothing of his wish for her to undo it, Sally experienced only his displeasure and disapproval of her. Sally was silent through most of the first 40 minutes and tearful through most of the second 40 minutes.

Throughout the two-hour session it seemed to the observers that Mr. Dyal exaggerated his guilt and tried to accept sole blame for the family's trouble. He tried to shield his wife and daughter from blame and behaved as if they were fragile and vulnerable. Often he spoke simply to relieve his wife of the necessity of talking through tears; for example, when Mrs. Dyal wept as she discussed her own failure to complete school. When he spoke to protect his daughter, he seemed to do so more from some fantasy of what he thought she felt than from a truly empathic understanding of her.

When Sally left the room with the social worker, the interview with the parents continued without change in affect or indication that material had been less sincerely presented in Sally's presence. The team deferred analysis of the obvious pathological condition indicated by Mrs. Dyal's overreaction to her own educational history, her readiness to live in a trailer, and Mr. Dyal's difficulty with giving recognition to the young womanhood of his daughter. Instead, they suggested that Mrs. Dyal would be able to present a more attractive feminine model for her daughter when her health improved and her husband could appreciate her more. Then, she might be content with her own career as a wife and mother rather than seeking vicarious pleasure from her daughter's career as flirtatious high school student. Supported by the team's acceptance and appreciation, Mrs. Dyal seemed then ready to examine further her excessive reaction to her own past school difficulties and her resistance to accepting her role as a mature woman and mother.

Mrs. Dyal revealed that some of her own school failures were due to illnesses, some were a rebellion against a father who insistently planned her school career. She rebelled in order to avoid being consumed by this incestuously toned relationship with a father who had not been a part of her life when she was between

the ages of 3 and 16. She explained, "When you don't grow up with your daddy it's just like he's not your daddy." In an individual session, the social worker was able to help the daughter with her feelings of guilt over being so exploitative and deceptive with her parents. As freer communication developed within the family during the joint and individual interviews, Sally gained a new view of her parents' requirements and restrictions. She saw them as less punitive and as having genuine concern for her welfare. Sally even began to appreciate that some of her parents' unreasonable requirements and pressures on her were related more to their own problems with their past than to her. Sally was then able to turn to such realistic problems as how to enjoy friends under the family's circumstances of crowded living quarters in a house-trailer.

Mrs. Dyall became less guilty about her legitimate need of attention from her physical illnesses. No longer feeling that her difficulties stemmed so much from being a blameworthy failure, she could express the feeling that she deserved something more than a trailer as a home. She could behave toward her daughter more like a self-respecting mother than a whining nag and critic.

This seemed to be the help the father needed, since he had already begun negotiations to build a house, but to build it for his daughter's sake alone. Mrs. Dyal noticed that she herself was augmenting this problem because she could never dare to ask for anything for herself.

In the final one of the three 40-minute sessions, a team-family conference, Sally particularly appreciated the opportunity to express openly a wish for a place in the house which her mother wanted and might continue to enjoy after Sally was grown and making her own home. While acquiring the house was not presented to her as an incest problem, it was clear that the house would somehow have been charged to the daughter's account, and the team supported the idea that she could not afford its emotional price.

Sally ended her crying as the parents accepted their part in her difficulties and as they began to speak of her behavior as being in

part an expression of their own attitude. Her participation in family patterns was shown by the way she too blamed herself for all of the family troubles.

The team's decision that more than intake had been accomplished was based on the way family members began to put to work what they had learned in an hour and a half. Mr. Dyal made a number of increasingly pointed attempts to summarize his new understanding. Essentially, he said he regretted having used his wife to accomplish his own selfish ends in molding his daughter's behavior. They were then able to place some confidence in self-rehabilitating forces that had been at work in the family since their contact with the referring psychiatrist. Their own behavior toward each other and toward the team was used as validating evidence. For example, Mrs. Dyal was impressed with her own past difficulty accepting help in contrast with her present feeling that she could both ask for it and criticize it.

This was early in November. Follow-up was scheduled for two months later. Formulations about the case and data from the follow-up contacts at two, six, and nine months follow the typescript of this, the November session.

TYPESCRIPT

DR. SERRANO: How did you come here?

MRS. DYAL: About six weeks ago, we went in and talked to Dr. W. A friend from Texas City made an appointment for us because we live 100 miles down the coast. And at the time my husband was out on the job, but of course, he knew that we were coming. Dr. W. questioned my daughter and talked with her, and he questioned me and he came to this conclusion, the best that I can understand it. He said this: that it was like a social behavior problem that we were having with our daughter. And of course, since we saw Dr. W. we have talked quite a bit and we have come to what I believe is a better understanding about a lot of things. We think that possibly she understands us better and we understand her better, but still there's things that I feel that possibly we need help on. One of the

main problems that we were having that was bothering me most is the fact that, well, Sally would tell us things that were a sort of an imagination and she would tell it for the truth. And it bothered me, and I talked to her quite a bit about it, and I asked her why she did it, and she said, well, at first she'd tell me she didn't know, and then she came to the conclusion that it was to gain attention. And since we talked to Dr. W., Sally has—uh—[*Tearfully*] tried to help herself and she is trying not to tell things of that sort.

DR. MACGREGOR: Were your folks hard to level with? [*Pause*] To be honest with or be honest about? [*Pause*] I wouldn't ask an easy question. [*Pause and chuckles: Sally looked toward her mother.*] Oh, come on, I know Mother can talk. Let's see if you can tell us something about what the problem was as you saw it.

SALLY: I just thought they were too hard on me, and I guess it was for my own good and I just didn't understand it.

MRS. RITCHIE: In what way, Sally?

SALLY: But they just seemed like, I don't know. . . .

MR. DYAL: Well, tell her what you think—uh—why you thought we was too hard.

SALLY: Well, I just didn't understand why they didn't want me to go certain places, and I thought it was just because they didn't want me to go, and. . . .

DR. MACGREGOR: So it's the restrictions on your social behavior that you think of to tell us about now. Restrictions on where you go and when you go?

SALLY: Yes sir, but I—uh—I know it's for my own good and. . . .

MRS. RITCHIE: Just doesn't feel like it. [*Pause*]

DR. MACGREGOR: Well, I suppose your folks had every intention of saying things for your own good, but did it feel, on rethinking it, that there were some areas where the reasons for strictness were not clear? [*Looking at Mr. Dyal now*] Not clear from her standpoint?

MR. DYAL: Oh well, a lot, I would imagine that. . . . You see, I'm not that old that I don't remember how I was whenever I was her age. I had the same resentment that I know she's got of the

things that I wanted to do, and I know now wasn't the right things for me to do. But I still had the same thought that she had; that it was all right to do them. I mean, I'm not that old that I can't remember the things and—uh—I imagine one thing that made things more difficult at home. I work out on a boat most of the time and whenever I do come in—well, uh—the change from the noise out on the boat to the quietness at home and my nerves is always being on edges, I was irritable, and probably cross when I shouldn't have been. But as far as the restrictions on what I thought she should have done, well, I mean I still had that same conviction that I was doing the right thing, not only for her but the other two children's welfare. [*Voices interrupting each other*]

DR. SERRANO: Let's go back a little bit. How long has this been going on?

MRS. DYAL: Well—uh—about her not telling me the truth is something that has been going on for just a number of years, but I thought, I just tried, it's something I tried to talk with her about and maybe she would outgrow it just after a while, and maybe she just wouldn't do it. [*All of this rather tearfully spoken*] But I think that maybe when she was quite young. . . . [*Tears in profusion*]

DR. MACGREGOR: This is the place for tears. We don't mean to talk about anything but serious business. [*Tears for a while*]

MRS. DYAL: We moved around quite a bit, [*Still tearful*] and I feel that possibly I was too demanding about her grades. As I look back on it, maybe that's what caused her to start not telling the truth.

DR. SERRANO: Uh-huh.

MRS. DYAL: I think maybe that might be why. I thought and thought and tried to reason out and help her, and it got to the point when I'd say, "Sally, how are you doing in school?" And she'd tell me, "Why, just fine, Mother." And of course, when her report card got home it was everything but fine, but I can say this, Sally always brung her report card home to me.

DR. MACGREGOR: Discussion about homework and that sort of thing, does it usually, or has it frequently, brought you to tears?

MRS. DYAL: I wouldn't say that, Doctor—uh—I've been sick quite a bit, and it's something [*Sighs*] that [*Blows her nose*] I know hasn't helped the children out any, but I have done the best I could, and I am a lot better than I used to be. I think that that maybe has a lot to do with. . . .

DR. MACGREGOR: [*Interrupting*] I don't mean better or worse, I mean do you get moved. . . .

MRS. DYAL: Yes, sir.

DR. MACGREGOR: [*Continuing*] to tears when you are on an issue with your daughter?

MRS. DYAL: Yes, sir.

DR. MACGREGOR: I suppose this serves as some kind of a lesson to Sally? Sally, do you cry easily? [*Silence*]

MRS. RITCHIE: You say you're better now. Do you mean you're better physically?

MRS. DYAL: That's right.

MRS. RITCHIE: Uh-huh.

MRS. DYAL: Much better.

DR. SERRANO: What has been your problem for so many years?

MRS. DYAL: Well, Doctor, I won't go into it. It's just been from so many things. I finally had to have spinal surgery. [*Tears*] And it's just been many things. I wasn't even supposed to have any children at all, and I have three.

DR. MACGREGOR: You have a lot of courage with all your tears, huh? [*Pause*]

MRS. DYAL: She's had bladder trouble since the baby was born. That was 12 years ago. It was just in the last two years we was able to find a doctor that was able to help her. I took her to bladder specialists or urologists from Brownsville or Harlingen all the way to New Orleans. It's just the last two years— isn't it?—that we was able to find out what all the trouble was.

MRS. RITCHIE: I see, uh-huh.

DR. MACGREGOR: With Dad out of daily life a good deal and daughter out of daily life in school a good deal—uh—is your life at home almost exclusively with the other two children?

MRS. DYAL: Oh, they're in junior high. [*Slight pause*]

DR. MACGREGOR: Well, then with Dad advertising himself as having memories of his youth, and—uh—Daughter having youthful ideas at this point, do these two forces kinda combine and make you feel left out? Is she able to mobilize Dad against you sometimes?

MRS. DYAL: No. [*Slight pause*]

MR. DYAL: I know what causes that. She—she resents me, and I resent her for her not being willing to listen to me. I mean, you tell her, "Whatever I say is the law." I know it's not the right way, but whenever I come in. . . . I admit that it could be that 90 per cent of the trouble is my fault, but at the time I thought I was doing the right thing by the way I was, but what I could see others do in the way I do. I was trying to steer her around my mistakes. If—I just. . . .

MRS. RITCHIE: Uh-huh.

MR. DYAL: My mistakes was a plenty. And I just know how I treated my mother and father, the heartaches and sorrows I caused them. It could have been my behavior caused my mother to die an early death from worry. She didn't have but ten children. I imagine I give her more trouble than the other ones put together.

MRS. RITCHIE: Is that right?

DR. MACGREGOR: It sounds like a pretty potent thing you have in the family history. Do I understand that Sally might be given the feeling now that if she doesn't toe the mark, this is likely to lead to the untimely death of her mother?

MR. DYAL: No, I wouldn't think, uh. . . .

DR. MACGREGOR: [*Interrupts to Sally*] Have you felt that kind of pressure on you? You might put it on yourself. Thinking of the family story that way.

MR. DYAL: No sir, I mean that never was discussed with the children. Neither one of the three children has ever worried too much about whether they give trouble or not. I mean, that I can see. It just comes natural for them to, I imagine, act like ordinary children.

DR. MACGREGOR: Sally doesn't strike you as a worrier?

MR. DYAL: Sir?

DR. MACGREGOR: Sally doesn't strike you as a worrier?

MR. DYAL: No, sir—uh—anything but a worrier. I mean, I just feel that she's happy-go-lucky just like—but it undoubtedly must not have been that way.

DR. SERRANO: Is that the way you were when you were growing up and gave so much trouble to your folks? Were you happy-go-lucky and didn't care?

MR. DYAL: Yes, sir, I mean nothing worried me, and I can see more and more that she is just like I was.

DR. MACGREGOR: She looks like a worrier to me.

MR. DYAL: Does she?

DR. MACGREGOR: Are you a worrier?

MR. DYAL: She could be. Because I know there wasn't nothing that worried me, and—uh—the only thing that worried me was that dark come too soon and it. . . .

DR. MACGREGOR: [*Interrupting*] Extreme behavior that's guaranteed to lead to unhappy family situations must be driven by some kind of worry.

MR. DYAL: Well, I know that the family life could have been a lot happier had I been able to seen my mistake of being too grouchy, or too sharp with them, or cross whenever I did come in.

DR. MACGREGOR: It seems to me that all of you here are prepared to take more than your share of credit for your family difficulties.

MR. DYAL: No, sir, I'm just—I'm just giving it to you straight.

DR. MACGREGOR: It seems to you that a whole lot of it is your fault. It feels to Mother that a whole lot of it is related to her illnesses and her way of managing. How does it feel to you, Sally? [*Silence*]

MRS. RITCHIE: Well, Sally has already told us that she feels now that her parents were trying to do the right thing, steering her in the right way.

DR. SERRANO: You never communicated these things around the family?

MRS. DYAL: Yes, sir, we talked about them, and. . . .

MR. DYAL: [*Interrupting*] Well, just what I talked about here this morning. No, I never—I— It's just been since the way it's been—I mean to this point. I've been out on the boat. During the past two weeks I've had a lot of time at night to look back, to take time and look back, and see my mistakes. Whenever she was four years old, well, not quite four years old, the baby was six months old, I took them on the towboat to live with me for 18 months. And her and her brother and baby sister—well, it wasn't a large tug. I know now that the pressure was on me. I wasn't kind to none of them as I should have been because of the pressure that I had on me that maybe something would happen to wreck the boat, to tear it up and sink it, and lose all of them. It could have started even back then that I—uh—didn't show the proper love. Of course, the love was there, because I've always tried to put my family first. I've done anything that was right for to make a living for them to try to have them with me. 'Cause whenever you have to work on the boats like I did back then, the only way I could see them was to take them on the boat with me.

MRS. RITCHIE: And you wanted your family with you, but you felt like it was a dangerous situation; you couldn't help but worry.

MR. DYAL: Yeah, and uh. . . .

MRS. RITCHIE: Yes, I see.

MR. DYAL: And I wanted them to be as safe as they could be while they were there.

DR. MACGREGOR: [*Interrupting*] Being captain of a boat and captain of a family at the same time, you looked like a tyrant, huh?

MR. DYAL: Well, it was—it was. . . .

DR. SERRANO: [*Interrupting*] When was that?

MR. DYAL: That was whenever— It was just two years ago, when she had the back operation. My wife was cooking for us.

DR. SERRANO: You were all together on the boat?

MR. DYAL: My daddy, my wife, and three children.

DR. MACGREGOR: Did you have any other help on the boat?

MR. DYAL: No sir, my daddy helped deck, and my wife decked, and I. . . . [*Momentary silence*]

MRS. RITCHIE: Are you still working on tugboats?

MR. DYAL: Well, it's crew boats now instead of tugboats. I work out of Galveston here for three months. That was three or four months ago, the hardest work I'd done, the most pressure I had had in the last six or eight years.

MRS. RITCHIE: [To Mrs. Dyal] How did you find him when he came home from trips, when he was under all this pressure?

MRS. DYAL: Well, I realized that the type of work that he does—[In tears] I will say this. I don't think that we can have a better daddy and husband. I know at times he is under pressure. When he comes home, well, especially with the problem with Sally, trying to cope with the situation, it certainly hasn't helped his nerves out any. But he's definitely not hard to get along with. I think either one of his children could say that.

DR. MACGREGOR: By the time he gets home you need him just as bad as any of the kids do.

MRS. DYAL: That's right.

MR. DYAL: And—uh—if I'm talking out of turn, tell me so I have showed partiality I didn't mean to. I done more for her when she was a baby than I did for the others, because she was our first one, and I made her doll beds and just a lot of things that I didn't take time out to do for the boy or the baby, either one. But I imagine the time I should have been showing more affection for them and doing for them, I was too busy making a living for them, and I can look back and can see that I—I should have took more time out. And what I want to do is correct my mistakes now so that it won't have an effect on either one of the others, even if they are 12 and 14 years old.

DR. MACGREGOR: Well, Sally, I still don't get the picture of what it is you felt the need to campaign for most. What is it that you had to struggle toward that seemed hard in relation to what the family wanted? [Silence]

MR. DYAL: Now, Baby, tell them what you think. That is what we're here for. [Long pause]

SALLY: Well, it's just like I told my mother, no matter how

much they say that they love you [*Crying*] if you don't feel it, it's just not there.

MRS. DYAL: That's what she's told me. And my goodness, we love her!

DR. SERRANO: Could you be, perhaps, more specific? What is the thing they don't do that you would like for them to do? [*Long pause*]

SALLY: Well, I see now that they do everything for me. [*Tearfully*]

DR. SERRANO: What was in the way before that you could not see? [*Pause*]

SALLY: And then not letting me go places, I know that it was probably me, 'cause when I didn't get to go places, well I'd—I'd take out or something. But I felt like I was tied down, or in a cage, or something. And any time I got an opening, I went. [*Tearfully*]

DR. MACGREGOR: Do you have a regular group of girl friends that welcome your coming over to visit with them? [*Pause*]

SALLY: I'd say yes.

DR. MACGREGOR: Do you have the experience that sometimes you can make more sense in talking to their mothers than to your own?

SALLY: Well, it's been that I just couldn't talk to my mother.

DR. MACGREGOR: I think most daughters find this at one time or another in their lives. It always seems that somebody else's mother is more understanding. [*Silence*]

MRS. RITCHIE: Somehow I have the feeling it's in relation to things you wanted to do, places you wanted to go, and friends you wanted to go out with. They didn't mention it, but I gather you wanted to date more than you did. Do you have a boy friend?

SALLY: Well, no one in particular, I mean. [*Pause*] Well, well, I feel like it is. . . .

DR. SERRANO: What was the problem there? They didn't like the boys, or what was it?

SALLY: Well, they didn't like them, and now I see where they were right in steering me away from them.

DR. SERRANO: They're not good boys, or what is it?

SALLY: Probably weren't.

DR. MACGREGOR: Well, if you felt unloved, you probably were ready to welcome, pretty uncritically, the attention of many people that you may feel more fussy about now. *[Pause]*

MRS. RITCHIE: I don't know why we keep going around and around. There were places she wanted to go and you wouldn't let her go, and this is vague. What sort of places did she want to go and you wouldn't let her go?

MR. DYAL: Well, it was the different groups that she wanted to associate with. They were questionable, and they just wasn't the right kind. They were the kind of characters I wanted to associate with whenever I was young. I know that they was not the right influences for even my boy to associate with, so I didn't think my daughter should be associated with them.

DR. MACGREGOR: Is there any group of people that you're afraid to associate with?

MR. DYAL: Now, well, what do you mean?

DR. MACGREGOR: You strike me as a guy who's not afraid to associate with any group of people.

MR. DYAL: Now that I can know how to deal with it, I'm not afraid because I might help them some kind of a way that could help them in their wrongness.

DR. MACGREGOR: How did it damage you in the past?

MR. DYAL: Sir?

DR. MACGREGOR: How did it damage you in the past to be less fussy?

MR. DYAL: You mean when I was young?

DR. MACGREGOR: Yes.

MR. DYAL: Well, whenever I got with the wrong crowd—'til I was 17 I hadn't ever dranked or associated with the group I associated with then. And whenever I got a taste of the bad side of life, well, I know what it led me to.

DR. MACGREGOR: Did you have a period of being an alcoholic?

MR. DYAL: No, sir, I stopped just before that I was, 17 years

ago, just before me and my wife married. I'd say that I was right on the verge of being an alcoholic, but since then I haven't touched a drop of any kind of alcohol at all.

DR. MACGREGOR: Wouldn't it be kinda ideal if you could feel you could trust your daughter with *any* kind of people? Counting on her taste and pick.

MR. DYAL: No, sir, I—I—because I—I—what I'm driving at, I couldn't protect myself whenever I got the taste of it. And I know, looking at her and the way she is, her attitude and everything. I mean, I'm no psychiatrist or nothing, but what I can see, that she was like I was. And about being in a cage, well, I had that same feeling. That's the first time she's ever mentioned that, that I've heard it. But being in a cage, I had that same feeling. It looked like the walls keep coming closer to me, and if I didn't get out of it, it'd just smother me. It's the first time.

DR. SERRANO: [*Interrupting*] You mention that you were close to becoming an alcoholic. What made you realize that this wasn't what you really wanted to do? How did you change?

MR. DYAL: On account of my wife. I mean she told me that before she'd marry me I'd have to make up my mind that it would either have to be my continued drinking or her. And—uh—I had prayed to the Lord that if it be His will for me to have her, that He would give her to me, and if that was what was keeping me from having her, well, I wouldn't let something as damaging as liquor stand between me and her. And that was—that was all there was to it. I mean, that's what caused me to. . . .

DR. SERRANO: In other words, through her love you were able to—uh. . . .

MR. DYAL: Yes, sir.

DR. SERRANO: To change your life and do things in a different way.

MR. DYAL: Yes, sir.

DR. SERRANO: Don't you think that this is what is going on now? A clear expression of love is helping Sally now to review her interest in life and do things in a different way.

MR. DYAL: You mean me showing outright more love and affection for her now?

DR. SERRANO: Yes, you and your wife.

MR. DYAL: Since all of this just come up? This is what you mean?

DR. SERRANO: There seems to be a correlation between these two things. You were rescued from that through the love of your wife, and it may be that, although Sally hasn't gotten in any such trouble, that she was leaning, according to the way you look at it. You found this could be stopped through the clear expression of love.

DR. MACGREGOR: You started out in the recent past saying this behavior of your daughter's must be some kind of sickness. Today you say her difficulties make a lot of sense in view of what she has been dealing with.

MR. DYAL: I mean, I think that if it continued going in the path it was going, that it could be a sickness. If I hadn't made the changes that I had 17 years ago, I know where it would have led me. I may not be making sense to you.

MRS. RITCHIE: It makes very good sense. Uh-huh.

MR. DYAL: But I . . .

DR. MACGREGOR: Sickness seems to have been something like the breakdown in communication. You folks weren't making very good sense to each other. You weren't able to talk to each other. The words come kind of with difficulty even now, because you are not used to expressing these things with each other.

MR. DYAL: Well, I know that whenever she . . . My wife can tell you that. She wouldn't have to say over a half-dozen words and I . . . It would just come wrong to me. Well, right then I was ready to fuss and say what I wanted to have said and not wait long enough for her to talk and express what she wanted. I mean, I'm hardheaded and I have been so. But to erase the trouble that is started, well, I'm—I'm not too stupid to soften my head up enough to help my family. After all, that's all I'm working for. If we can't have a happy home, well, my work, it just don't mean nothing to me.

DR. MACGREGOR: Well, I gather Sally is hardheaded and this is tempered with some of Mother's tenderness. [Pause]

MR. DYAL: And I know she would go to her mother with things, and her mother would talk with me. I would turn right around and have her mother to let her do them, and all the time it would be unknown to her that I was the instrument of causing it to be done. I can see now that I should have let it be known that I was helping her mother to make that decision to let her do them. [Pause]

MRS. RITCHIE: Yes, you find yourself, I'm sure, in a rather difficult position when you're away from home so much. It has to be kind of up to your wife.

MR. DYAL: It comes back to her in just little parts and not the whole picture of it.

MRS. RITCHIE: You know, I really like Mr. Dyal's description. He didn't take time to listen to his daughter. And she already said that they didn't understand her, and she didn't understand them. And now he says, "If I stop and listen, I'll be able to understand better and—uh—do better."

MR. DYAL: I've *had* the time before, but I just didn't stop to take that time.

MRS. RITCHIE: Yes, sir.

DR. MACGREGOR: But she gave up on her folks a long time back, I feel.

MR. DYAL: Well, I would say she give up on her folks three or four years ago. I mean, I can look back now and see that's that whenever I started losing her, if you can put it that way.

MRS. RITCHIE: Uh-huh, three or four years ago, that made her. . .

MR. DYAL: Twelve years old.

MRS. RITCHIE: Around 12, uh-huh.

MR. DYAL: And I just—I just always wanted them to be something that everybody could look at and, you know, think, "That's an ideal child."

DR. MACGREGOR: [Interrupting] Has some of this desire to have an ideal child who associates with the right kind of kids been some way of advertising yourself?

MR. DYAL: [*Interrupting*] It goes back to—it goes back to whenever I was between 16 and 18 years old. I didn't want her to be like I was, like—you know what I mean, I—I. . .

DR. MACGREGOR: [*Interrupting*] But you've helped her kinda feel that she has something to be ashamed of in her background.

MR. DYAL: No. If I did, I didn't—uh—I didn't implicate it.

DR. SERRANO: Yes, but the thing that seems to come out is that somehow she has the task to repair things that you did in the past.

MR. DYAL: For her. . . [*Interruption*]

DR. SERRANO: If she does well, she can so repair your faults of the past.

MR. DYAL: Well, now, she can be thinking that, but. . .

DR. SERRANO: Whether she thinks it or not, this comes out now. You say it now. You want her and the other children to be an example so you can now compensate for all those things that you did.

MR. DYAL: In the back of my mind it's probably that. The people that I was raised around knew just how I would do to my—behind my father's and mother's back. And I imagine back there I want them to be so that the people can say, "Now those children is not doing like he done, but he's been able to steer them around his mistakes and they're really doing the right thing." I mean—uh. . .

DR. SERRANO: The thing is that then, instead of children gaining their own experience and becoming independent, taking care of themselves, they have a task, some kind of homework to help you to repair that past.

MR. DYAL: I understand.

DR. SERRANO: That puts a lot of pressure. Perhaps it may be as much pressure as the one that your wife was telling of, for getting good grades. [*Pause*]

MR. DYAL: And I know that my wife has talked to me about it before—that I shouldn't expect them to do the things that I didn't do.

DR. MACGREGOR: What was your school life?

MR. DYAL: In what way?

MRS. DYAL: Do you mean mine?

MR. DYAL: Oh well, that's different! [*Laughter*]

MRS. DYAL: Well, Doctor, I went through high school; I was out quite a bit. But I didn't make my grades, and it got to the point that Sally wasn't making hers, definitely wasn't. And I. . . . [*Pause*]

DR. MACGREGOR: You've been there!

MRS. DYAL: Yes, sir.

DR. MACGREGOR: And was all this so bad for you?

MRS. DYAL: Well, I guess it was. [*Pause*]

DR. MACGREGOR: [*To Mrs. Dyal*] Are you trying to represent yourself to your daughter as a failure?

MRS. DYAL: No, Doctor, I don't think I'm a failure, not one bit. I really don't think so.

DR. SERRANO: Did you feel a little bit guilty for not having produced in high school the way you should have? That makes all of us feel that—uh—uh. . . .

MRS. RITCHIE: [*Interrupting*] It's the same thing. "Don't do like I did, do better!"

DR. MACGREGOR: My kids are always forgetting that my high school marks weren't any good either.

MRS. DYAL: Well, I—I—I'll start back here. I was out of school much of the time, very much.

MRS. RITCHIE: You were sick or you were truant?

MRS. DYAL: That is right. And, considering everything, I certainly didn't do the best, but I went through high school and I was in business school when—[*Silence; tears; more silence*] I was out for a month, so I didn't even go back. [*Tearfully*]

MRS. RITCHIE: Something very hard happened to you then.

MRS. DYAL: Well, it was the same old problem—if it wasn't one thing it was two or three. [*Crying*]

MR. DYAL: It's all right, just stop. [*Whispering it*]

DR. MACGREGOR: Do you feel awfully bad about not finishing business school?

MRS. DYAL: Not really.

DR. MACGREGOR: School got to be a terribly important thing to you. I wonder why.

MR. DYAL: Well, since you mentioned it, that is the first time it's

really dawned on me like that, that she's thought about. I've thought education important to a certain extent, but—and my children is never known that I felt this way—it's not a disgrace 'cause, like I told you—like being in a cage—well, when I'd get in the schoolroom I—I knew I was in a cage. [Laughter] I knew it wasn't no remedy, but for me to get out of that schoolroom. Uh, whenever I wanted to, I could make as good a grade as any child in that room. But the pressure would get on me that wasn't where I belonged. You see, I was crippled, and my father give me just about anything that I can think of that I needed. Horses, bicycles, and boats, my own speedboat. And when I wasn't but about 14 and 15 he even got me a better car than what he was driving. That made me not want to stay in the schoolroom. But I always wanted my children to do good.

DR. MACGREGOR: So you had this pattern in your background—of Dad wanting more for you than he had himself?

MR. DYAL: No. It wasn't that he wanted more for me than he had. It was that I knew how to get more out of him than any of the rest of the children could. And I mean, by me being crippled and I had suffered so much. I used that as a lever over him and my mother to get what I wanted.

MRS. RITCHIE: Uh-huh.

MR. DYAL: And I just—I know now that I was just wrong in my doing that, and my other brothers and sisters resented me for it, but then I didn't care, all that resentment. Just so long as I got what I wanted.

DR. MACGREGOR: I was thinking, along Dr. Serrano's line—where he sees your daughter as having the additional task in life of undoing some of your mistakes, she has the additional pressure of facing not only her own anxieties about school, but Mother's tasks, her worries about school.

MRS. DYAL: I don't feel that way, Doctor. This is the way I feel about Sally's education. We have moved constantly. And I felt that it was my job, my duty, [Tears] to be with the children, help them, try to see to it that they got a good education. Any why shouldn't

I? And yet I feel now that possibly I expected too high of marks from Sally. Sally is very talented in piano and voice. But with her book work in the lower grade, when she brought home a C—I don't feel that I really fussed over her—I was really honest with her. I'd say, "Now, Sally, you made a C. You could only make one grade lower, that's a D. And you know we move constantly; [*Tearfully*] just work hard, just keep the grades up."

DR. MACGREGOR: Sally, has moving a good deal had anything to do with any advantages that you can see? [*Pause*]

SALLY: Well, it's widened my knowledge about a lot of things. I mean. . . . [*Pause*]

DR. MACGREGOR: Uh-huh. This would be my impression. Kids that grow up all in the same school system seem to be awfully narrow in their way of life. Students who have seen other principals, and other teachers, and the way other schools operate, aren't so overawed with the one.

MRS. RITCHIE: Do you think it's made it easier or harder for you to make friends?

SALLY: Well, it made it easier. 'Cause sometimes we'd stay there about a month and then we'd leave, and then it was just like going into another crowd, and I just would get in with them and. . .

MRS. RITCHIE: And you would find new friends everywhere you went? This is good, to be able to make friends quickly and easily.

DR. MACGREGOR: Well, has this been your impression, that it's made making friends easier for her?

MRS. DYAL: Yes!

MR. DYAL: That hasn't ever been her problem. If anything, she's had too many. I mean, just everybody has been her friend for that part.

MRS. DYAL: Sally does make friends with everybody.

DR. MACGREGOR: There must be a lot that's good in your family life that makes this possible.

MRS. DYAL: And I am glad that she does. But when I know definitely that somebody is not the right kind of friend for Sally to have. . . .

DR. MACGREGOR: It is your job to get that opinion out.

MRS. DYAL: I feel that I should talk to her and tell her so.

DR. SERRANO: Somehow I get the impression that it has been much more difficult for you to adjust to so many moves than it has been for the rest of the family.

MRS. DYAL: No. In fact I love to move. I don't feel that it has ever bothered me. I grew up that way. Marrying L. M. hasn't made that much difference in my way of living. It's just that Mother and Dad separated when I was 3. [*Tearfully; pause; blows nose*] As far as the [*Tears*] moving, it really doesn't bother me. [*Pause*]

MR. DYAL: And something else that could help for her to be that way is the last six years we have lived in a house-trailer. You can't have as many friends to come and visit with you in a house-trailer as you can if you had a home. And that can be some of the problems. We moved to Coast Town, and we liked it. We had lived there before. I bought two acres of land, and I just about got them paid out and we dealt with a builder out of Houston to build us a home and all. See, Sally is not getting any younger. And we wanted to try to—I wanted to do all I could to help her get straightened out.

DR. MACGREGOR: You building that house for Sally?

MR. DYAL: Uh-huh, mostly; yes, sir.

DR. MACGREGOR: That's too much expense for her to bear. I don't think she can afford a house.

MR. DYAL: She ain't going to be the one to buy it, but I. . .

DR. MACGREGOR: No, but if. . .

MRS. DYAL: We want it for her.

MR. DYAL: I mean for it to help her.

DR. MACGREGOR: The project is on her shoulders; this is something done for her.

MR. DYAL: Yes, but this is the first time this has been mentioned, Doctor. She don't know that it's for her, but I'm telling you now so you can know what I—what I feel toward my family. This is the first time it has been mentioned that it is for her. But—uh—others will reap the benefit from it; in fact we all will. But I'm going to

the special effort to do it now even though it looks wiser to wait, with the country looking this way and everything. But still if it's going to be a depression or something, I'll just have to take it with the rest. But that's what I was hoping to do it for. I don't know if I make myself clear.

DR. MACGREGOR: Do the other kids kind of enjoy living in the trailer?

MRS. DYAL: No.

MR. DYAL: No, they're getting too big.

MRS. RITCHIE: How about you, the lady of the house?

MRS. DYAL: Well, I want what's best for the children. I'll say this, if it's just husband and wife, trailer living I'd say is all right. It's large enough. But I do realize with our children we need a larger place, and I want it for them. And really that's the way he feels about it.

MR. DYAL: My work hasn't changed any. I'm—I'm still having to drive back home on my days off to stay in one place.

DR. MACGREGOR: Does it then seem that Coast Town is about the best place for you?

MR. DYAL: Well, it's about center about where my work will be. Coast Town is about halfway between here and Corpus or halfway between Brownsville and Orange, Texas, and that's where my work will be, and. . . .

MRS. DYAL: The children like Coast Town a lot.

DR. MACGREGOR: Well, I have some mild objection to the "everything for the kids."

MRS. DYAL: Well, I guess you have, and you're probably right.

DR. MACGREGOR: Well, the trouble is that the kids can join you in that effort. Kids try to identify with their parents. If the parent's main objective is them, then they've got to make themselves. . . . It's a puzzling way to grow up.

MRS. RITCHIE: I think Mr. Dyal has already pointed out this has happened to him.

DR. MACGREGOR: Uh-huh. These children are going to want to grow up and have their own families, be respected by their families.

And the model of mother living for child is a puzzling one to follow. Children are the *product* of your relationship, not the *object*. [Pause]

(The following is an abstract of the next 15 minutes of this session.)

The social worker suggested that the whole family wanted and needed new quarters. Mr. Dyal agreed. A therapist suggested that Sally expresses Mother's desire, in part because Mother cannot permit herself to ask for anything for herself. Mr. Dyal tried to blame his own negligence in money matters. Another therapist reiterated the interpretation that the parents' inability to feel worthy forces them to charge what they purchase for themselves to the children's account. In an economy of emotional scarcity this support of adult needs was shown to be more than children should bear. The parents accepted the interpretation and future responsibilities by admitting that what is good for themselves is what is good for the children, and that the house is a sound investment financially.

The tape continues.

SALLY: Well, I feel like it's been all my fault because of the way things have been. [Tearfully]

DR. MACGREGOR: Well, of course, if everything is for the kids, then if the kids don't pay off, the investment's a waste. I suppose that is loaded pretty heavily on you. But I think you'd better let them put their investment more in themselves. [Pause] It seems like a family pattern here to take all the blame.

MRS. RITCHIE: Uh-huh. [Pause]

MR. DYAL: Where's the trouble then, Doc?

DR. MACGREGOR: You know, I've just got some kind of feeling that we're in on the end of the trouble.

MRS. DYAL: Well, Sally made the remark this morning when we were coming over, she said that she didn't feel that we really needed to come.

SALLY: Because I felt like if I asked to go somewhere, well, no

telling what they'll do. Well, last week—went to the football game Friday night. Saturday night I asked, "Can this boy take me to a party?" Well, I went, came home. Then tonight there will be something else going on, and if we get back in time and if things turn out right, well, I plan to be able to go.

MRS. DYAL: See, what was happening. . . .

DR. MACGREGOR: You deal more responsibly with your time.

MRS. DYAL: I was trying to let Sally go places, to be with her friends, but Sally would slip off after the. . . . [*Interruption by Sally*]

SALLY: And it's because, the least little opening I got, I just left. [*Tears*]

DR. MACGREGOR: You were having trouble leveling with each other all the way around.

SALLY: I was just tied up somewhere, and when I would get a chance to get away from the house, it could be a church party, I'd just take off.

DR. SERRANO: Thinking perhaps, well, there won't be a next time. So let's make the best use of this one opportunity.

MRS. DYAL: But I—I talked to Sally and Sally told me, "Mother, well, I won't do that again." And I would let her go again.

DR. MACGREGOR: [*Interrupts*] Well, I hear from one department here, that the social life seems more comfortable, but—uh—isn't all this going to be at some expense to getting your schoolwork done?

SALLY: Well, I get my schoolwork done.

DR. MACGREGOR: Well, now you have a bad history in this. A history of saying the schoolwork's done and that the marks are on the way up, and then the report comes out and makes a liar out of you.

SALLY: Well, [*Pause*] up until we came and talked to Dr. W. And it's just like I told her, no matter how much I would study, if the interest wasn't there to do anything, schoolwork, or just even live, if I didn't have the interest to do it, it just didn't pay off.

DR. MACGREGOR: This makes real good sense. The number one

problem that you've been grappling with hasn't been school anyway. It's been some kind of plight at home. And maybe if the tension eases up on the plights at home you'll have more attention to give your schoolwork.

SALLY: And I . . . She says, "Well, I'll see when the report cards come out." But my grades have come home from my teachers, and, just like my American history teacher told me, it's just like I'm a different person this six weeks and that I'm just doing better.

MRS. DYAL: I've gone in and talked to her principal and some of her teachers and they said this. They said—uh—Sally evidently wasn't a problem, as far as you would call a problem child, in school. She doesn't get in trouble, she is not ugly to her teachers, she is well liked by her teachers and the children. Sally just didn't work!

DR. MACGREGOR: In a way, she's been draining off a lot of emotional tension of yours which is—uh—a pretty big task.

MRS. DYAL: I—think so.

DR. MACGREGOR: But—uh—it might be a better idea to—if there's any possibility that school marks aren't going well, to let your mother know about that, too.

SALLY: Well, if I—if it had been that I could come home and talk to her, maybe I would have told her. "I'm not doing so well in this; I'm not doing so well in that." But I knew what she expected, and I just couldn't. . . . [*Cries*]

DR. MACGREGOR: But school failure is a thing that's been disturbing to Mother.

DR. SERRANO: Is that because you cannot take it?

MRS. DYAL: Well, I can take it, but like I said a while ago, I felt that it was my job.

DR. SERRANO: To get an education?

MRS. DYAL: To see to it that I took care of the children. And help them.

DR. MACGREGOR: About all you can do is lead them horses to water. [*Some laughter*]

At Mr. Dyal's suggestion the team investigated whether Mrs. Dyal's problem with marks does not represent an attitude that she is responsible to her husband for the children's difficulties, and that this gives Sally a measure of control. This lead was not fruitful except that it led to more reaffirmation of the father's intent to assume responsibility directly.

MRS. DYAL: Really, bringing Sally in the first place to Dr. W., it was this feeling. I wanted the best for Sally. I didn't want something to happen to Sally, and—uh—it was getting to a point that I didn't know what to do or to expect next.

MR. DYAL: Well, I'll tell you the reason I come in here! It was to help get some help for *me*. Find out what was wrong with me. I—I—my wife wrote me a letter on the job and told me she was bringing Sally in. Well, I—I figured that I was the one that needed help, as well as Sally did. From then up until now, it's what I told you a while ago. I don't want to take up no more of your time but. . . .

DR. MACGREGOR: Family processes are a lot stronger than psychiatric treatment, and if you didn't react that way, then I think you would need a lot of technical work on this. But apparently what happened was that the thing ran so far that a crisis built up, and this crisis made you think. It did not throw you all to pieces.

DR. SERRANO: Yes, as you say, these things have occurred for years, but this is the first time that you spent time thinking. Something forces you to do something about it. You couldn't stand this situation any longer. And this is what makes things turn out in a better way. People tend to bring things up to date. We renew things and get a brand-new model.

MRS. DYAL: I feel that that's what's happened. Since things really came to a boiling point, it—I got to the point that I didn't know what to do next. I—I—I talked to Sally. I tried to reason with her. I tried to explain to her. I tried to get closer to her, and sometimes I felt like I was getting closer to her, and then other times we were just. . . .

DR. MACGREGOR: Now there is bound to be still something of a problem of leveling with each other. And also, when you start leveling with each other, you confuse each other a bit. You may not be used to it. It would be a good idea if we break up here for a little while and talk separately and come together later. Let's see if there are some things that are difficult to say in each other's presence.

MR. DYAL: I myself, I've said. . . .

MRS. DYAL: [*Interrupting*] I've said we have come because we wanted to talk about things, and Sally may have something, and it's her privilege if she wants to talk to you about it. It is her privilege. I want her to. If there are some things that she wants to talk to you about it. Discussing L.M.'s younger days—we didn't discuss them in front of the children.

DR. MACGREGOR: Well, this is too bad, really. Here is a guy who has been up against some pretty serious obstacles in living and then has come out in a right respectable way.

MRS. DYAL: That's right, it's a miracle, it's a miracle.

DR. MACGREGOR: Oh, go on! It's not a miracle.

MR. DYAL: Yes sir, I figure it is, by the way that I was going, and I just knew that by Sally having been like me. . . .

DR. MACGREGOR: You don't think that you're just made of the stuff that would triumph over those obstacles.

MR. DYAL: Well, I'll tell you what helped me to triumph over it, and that was a praying mother. Now that's the root of it. It kept me as far as it did until my wife was able to take over and help finish the job.

MRS. RITCHIE: Well, you know I like the way Mr. Dyal described himself as a black sheep with ten children in the family, but it didn't seem like he was so awful black to me.

MR. DYAL: Well—uh—no, I wasn't the black sheep. I mean that I got the stuff that should have been divided between the rest and I feel bad about it now.

MRS. RITCHIE: You gave them more trouble than the other nine put together you said.

MR. DYAL: But I could see that she—and—and. . . The Good Book tells us we're not supposed to judge. If we do, we're going to be judged. But I can see that she was trying—to follow in my. . .

DR. MACGREGOR: Is she as hardheaded as you are?

MR. DYAL: Yeah, that's what I was getting at, and just like I told you, the last two weeks I have softened up.

DR. MACGREGOR: But isn't your hardheadedness the thing that made it possible for you, despite any kind of people you were with, to finally make the kind of decision of what kind of life you wanted to lead?

MR. DYAL: Yes, sir.

DR. MACGREGOR: I count on her hardheadedness to carry her through situations.

DR. SERRANO: Yes.

MR. DYAL: [*Interrupts*] That's what it is. Up until now I've just had a one-track mind. It's got to be my way or that's all.

DR. MACGREGOR: Sally's had no way of building your confidence in her.

MR. DYAL: No, I didn't give her a chance to. It had to be the way I wanted it to be or not. You see—like I told you—the last two weeks I've had time to stop and reason things out.

DR. MACGREGOR: I bet you don't know much about how to be a young lady.

MRS. RITCHIE: Sally, let's you and me go across the hall and talk and leave them in here with your parents to talk. Excuse me. [*Sally leaves with the social worker.*]

DR. SERRANO: Despite what you call your being hardheaded, you have been able to be flexible enough at different times of your life to sit down and think of what you are doing and to make a change. Anybody that is able to do this, one way or the other, is much more flexible than the way you try to describe yourself.

DR. MACGREGOR: [*To Mrs. Dyal*] Here is the place where I worry about you a bit. And that is, if your life is overly dedicated to your children, are you likely to be growing? You're bound to get dull and uninteresting if you don't keep on growing. [*Slight pause*]

MR. DYAL: In what way, Doctor?

DR. MACGREGOR: Well, I don't know much about how to be a lady, either. [*Laughing slightly*] But I know that being entirely preoccupied with a younger generation isn't—unless your professional work is with kids and also with professional colleagues—this isn't a way to keep growing. These mothers that go to bridge parties and can't talk about anything but their kids are just dull to their neighbors. And it's likely to get dull for you and L.M. I'm wondering, is it possible to get things going in your life that—uh—make you grow?

MRS. DYAL: Instead of "All for the children?"

MR. DYAL: Well, now, I guess that you're right there, because whenever I come home it's always a discussion about the children. I mean, it's "this problem" and "that problem." And I imagine if you iron it down to our children it's. . . .

DR. MACGREGOR: [*To Mr. Dyal*] You have a full life. You meet other adults and you talk business and that kind of stuff so you're, by nature of your occupation, likely to keep growing. But she's stuck back home. And what are you going to do about that? [*Pause*] You don't come home and hear the latest political issue, I take it.

MR. DYAL: No. [*Laughing some; pause*]

DR. SERRANO: Yeah, there are a few angles here. One is that obviously the children are going to continue growing up, they'll move away from home, so this is going to more or less close business for Mother.

The two doctors spoke of the importance of continuing growth experiences. Mother was advised that if she were observed by the children to do homework on her own projects, this would be more effective as a model than would telling the children to do homework while she supervises them or keeps house. The attitude was elicited from both parents that while they did not need to finish school, the children should. The team suggested that this is tantamount to calling the children inferior and at the same time it labels

themselves as inferior objects of identification. The fact that the team regarded the parents as suitable objects of identification dawned slowly and temptingly on the Dyals. It simplified the problem as their resistance diminished. The father continued to excuse Sally's behavior as rebellion like his own.

DR. MACGREGOR: Well, I think it'd be well not to read too much of that problem into your daughter. It sounds like her problem isn't exactly the same as yours. She isn't fighting against the temptations to be out with a horse and a boat.

MRS. DYAL: No, she. . . .

DR. MACGREGOR: [*Interrupts*] She's preoccupied with a lot of adult-sized anxious problems and she's only 16. And she can probably tend to her schoolwork better if she had 16-year-old-type problems instead of all of her parents' anxieties. [*Slight pause*]

MRS. DYAL: Doctor, why does she tell me the stories like this? Uh—his sister's son had an accident where her car was completely tore up, but he came through it without a scratch. But she told this, "He got killed." She told somebody not too long ago, and it really worried me; that she wasn't my child; she was her daddy's child. He was married before but it hadn't been discussed.

This made it possible to show that Mother, by presenting womanhood as poor health and drudgery, repels the child and leaves Sally more at the mercy of fantasies about her father.

DR. MACGREGOR: Another thing, the quality of the storytelling is not poor, it is rather rich. Sally seems to have some creative ability.

MRS. DYAL: Yes. I can see it in her writing.

DR. SERRANO: She hasn't been tested. That's something that could be done, I guess. [*To Dr. MacGregor*] Do you think so?

DR. MACGREGOR: I worry about the message. Perhaps we'd better think in terms of what service we're going to perform. If we have another session like this ahead of us, then it might make sense that she be tested while the rest of the folks talk about their problems. But to have the upshot of *this* be only a testing session for

daughter, that is like saying, "You're handling things pretty well, but we think maybe you're nuts too." And—uh—I don't see this girl as. . . .

MR. DYAL: But she just took a test at school.

MRS. DYAL: Yeah, she just took one at school.

DR. SERRANO: Well, these tests, even when the child doesn't cooperate, it comes out through some other way.

DR. MACGREGOR: Guessing along at what the test results would be, we would probably find that she had sufficient intelligence and good creative abilities that are represented in her fantasies. Then we would probably also find her mildly depressed. Which is a sensible reaction to the situation she's in where she's a bit remorseful, feeling she has caused great unhappiness in her home, and really wasted some years of her own happiness.

MRS. DYAL: Well, I feel that since it really came to a point that we decided. I talked to her and told her that I felt like we should come in and talk to somebody that studied, that had more experience in dealing with a situation like we had at home. And she agreed, and that's when we came in and talked to Dr. W. Since we came in and talked to him I can see an entirely different Sally. I really can. And of course, in turn, I think she sees entirely different parents. I feel that from what she said this morning. I didn't finish what I was saying a while ago. When she said that she didn't feel like we really needed to come in, in other words, things really are better. The situation had improved so much. She said, "I feel that you all have changed—we all see things in a better light."

MR. DYAL: But I still—I'm not trying to pat myself on the back, but I still feel that a majority of the fault is with me. Since I had had time, or I took time, let me say it like that, took time to see where. . . .

DR. MACGREGOR: Well, I'll tease you a little bit. Nobody likes to feel very unimportant, and maybe you feel just a little more important when you blame yourself.

MR. DYAL: No, sir, it's not that, but I can feel that it's been took off of me.

DR. MACGREGOR: But the important contribution that you can make to your daughter, I think, is one that you are quite able to make. Not by telling your daughter how to become a young lady—this isn't something you know a heck of a lot about—but by how you treat your wife, by your interest in her, by the way you can help her get interested in continuing to grow instead of feeling like she has to produce marks in her kids to win your favor.

Dr. Serrano directed the interpretation to the desirability of daughter identifying with Mother, and Dr. MacGregor began the study of the way daughter became her competitor.

DR. MACGREGOR: I think your problem that was sensed in the referral to us, and here too as you told about your past life, that you had felt needy of affection for many years. It may be that at times what you need from your husband is more like what you needed from your father than just the adult interest. So that this makes you, in the eyes of your children, sometimes their competitor. And I think this matter of your neediness isn't something that you can put a period on. It's something. You'll have to recognize when it is you are responding to your own needs, to keep those to heck out of the children's way. And of course, the best remedy for neediness is anything that contributes to your self-respect. That is why you need some kind of adult activity besides going places with your husband. Uh—sure, dating your husband lets kids feel Mother is firmly first with Daddy, and they need to feel that, but also something that contributes to your individual growth. You need to have your own kind of baseball game. Whether you're a League of Women Voters type, or whether you're one who would rather study things of an intellectual sort, I think you ought to have some area in which you are seen by the kids as interested.

DR. SERRANO: Do you have any such activities?

MRS. DYAL: No, I don't have.

DR. MACGREGOR: Committee work in the church? [*Slight pause*]

MR. DYAL: Well, she figures that she didn't have the time to take away from the household duties and the children to take part in

the church. I mean—uh—she can tell you she's went. . . . We go to church.

DR. MACGREGOR: You may have solved your problem by going into this housing thing. After all, taking care of a house is going to be a rather brand-new experience for you. [Pause]

MRS. DYAL: I've always felt this way. [Tears] I knew that I couldn't do everything, [Tears] and what I could do, I wanted it to be the thing that would benefit the children. [Pause; tears]

DR. MACGREGOR: Well, it's flat easier when you don't feel well about yourself to do things for your kids rather than for yourself. They're sort of your captive audience.

DR. SERRANO: You have shown, despite all this display of tears, much more strength than that. You have all these back pains, the bladder trouble, and—uh—you are not here crippled or paralyzed. You have kept on doing the best for your husband and the children. You have much more strength than you are claiming to have.

DR. MACGREGOR: Well, I don't know how much your physical strength would allow it, but there some sorts of crutches that women use to get restarted in life, and one of them is to take on some kind of part-paying activity either in home or outside the home. You have had some kind of business training. It might be that you could get in some kind of activity that would add to the nice things that you could equip this house with. [Pause] I mean, earn for yourself.

MR. DYAL: Well, she has wanted to, but I have resented the fact that she hadn't got the time to do any outside things.

DR. MACGREGOR: That hurts your pride—you like to be the provider.

MR. DYAL: Well, yeah, I imagine in fact, yeah.

DR. MACGREGOR: It's true of me, I know.

MR. DYAL: But still she hasn't been healthy enough and, since—like you say—my pride figured, she's just not able to.

DR. MACGREGOR: I'm not prescribing it, because I don't know how much stamina you've got, but I have an idea that one way that will make it grow will be not by doing less but by doing more.

At this point the team had shown a readiness to accept the history of Mrs. Dyal's neediness and an expectation that with convalescence and adult appreciation she might enjoy womanhood in a way exemplary to her daughter. The team's dissatisfaction with the father's excessive claim to be both the model for Sally's rebellion and her champion permitted Mrs. Dyal to give the history of a relationship that had involved repression of tenderness toward her father and substitution of excessive of guilt about school achievement.

MRS. DYAL: Well, in the first place, me going into business was Daddy's idea. After Mother raised me Daddy told me—I—I'll put it this way. I don't blame him and yet he talked me—or he wanted me to go into business school. I stayed with Mother the whole time until I graduated. It was during the war, and I had some idea that I wanted to go to trade school and on to work. You know, a type of work with the hands. I went to visit Daddy, and instead of going back and going to work. . . . [Cries]

DR. SERRANO: I wonder why telling these things makes you cry so much. [To Mr. Dyal] Is this unusual, or is this the way she reacts?

DR. MACGREGOR: It probably has to do with over-all stamina.

MR. DYAL: She's fairly easy to cry, or make cry, whatever you put it, but this morning it looks like it's more so than usual.

DR. SERRANO: Well, I would say it's a lot of pressure and this is a place where people do cry a lot. It's difficult to tell a bunch of strangers, like we are, about secret parts of the family, and obviously they are painful. [Pause]

MRS. DYAL: Well, to be honest with you, I'm sick right now. And her condition does make me nervous. [Pause] And then having gone to help Sally causes me to be nervous. And I think that's what makes me cry easily.

DR. MACGREGOR: I think you've got Sally pretty well on the route to self-help. But—uh—do I gather that Dad's—uh—propaganda was more in favor of your becoming, for a while, a businesswoman or an office worker—that he was somewhat against your getting married very soon?

MRS. DYAL: Oh, he was definitely against it. In fact I didn't. I come home one afternoon from school and I just made up my mind that I was going back home to Mother, and I did. And I went into business school there, and I felt, well, my brother really was the one that had put up the money for it, [*Crying*] and I was going to finish, and of course, like I said, I got sick again, and I. . .

DR. MACGREGOR: Was this something that you felt you owed Dad—to finish?

MRS. DYAL: Well, I didn't owe to him, 'cause I just don't feel that I owe him too much. [*Tearfully again*] I know he's my daddy, but after the things that happened I really don't feel that I owe him too much. I respect him. I—I visited him occasionally. When you don't grow up with your daddy it's just like he's not your daddy.

DR. MACGREGOR: This has another side to it, too. His preference that you delay marriage—it sounds like he might have had more of a crush on his daughter than is usually in the open with a father who grows up with his daughter.

MRS. DYAL: Well, I don't know that he didn't want me to get married at all. He did want me to do office work. But he definitely didn't want me to marry L.M. And I was 18 years old. I knew L.M.'s past. I—I don't feel that I know all of L.M.'s past, but after all, what was before our marriage, that was before it, and we married and he has been everything that I could ask for in being a husband.

DR. MACGREGOR: Well, like Sally's past, it's probably been broadening.

MRS. DYAL: I don't feel that Daddy had any right to disapprove of L.M. Uh—that's the way I felt about it.

DR. SERRANO: How do you feel when L.M. disapproves of both of you—disapproves of some of the boys that Sally wants to date?

MRS. DYAL: Well—uh—the main boy that was in question was a boy that—uh—we knew absolutely nothing about. His family came to town on a job, moving from ———. And the boy came home on leave, and she come by, and said (we were at church), "Mother,

can I go, can so-and-so take me home and we'll get a cold drink and we'll come straight home." I said, "All right, Honey." And—uh—she didn't come straight home. And it was 10:00 or 12:00 before she got home.

DR. MACGREGOR: What you were coping with there was that Sally wasn't making much of an appraisal of *who* wanted her, she wanted to be *wanted*.

MRS. DYAL: That's what I—I uh—found out, but I can't understand why she feels that way. That's what I've been trying to understand and help. Why would she feel that she wasn't wanted?

MR. DYAL: Now I could have given her that—that feeling.

DR. MACGREGOR: She wasn't fighting so much to date a particular boy as she was fighting to date at all. Fighting for her independence.

MR. DYAL: Well, uh—it was her independence that she wanted 'cause I, I mean my growing up—I seen....

DR. MACGREGOR [*Interrupts*]: This is the kind of fight you can lose—when you fight on those grounds. They are forced to go heavier and heavier with the very guy that they are only using in a fight for independence.

MR. DYAL: That's exactly right.

DR. MACGREGOR: And the guy ends up feeling used.

MR. DYAL: But, I mean, I can see my mistake now.

DR. SERRANO: Well, well, she already is feeding us back the information that now she feels more confident. She feels that you are trusting her more; now she can—uh—answer. She's getting back home on time, not having....

DR. MACGREGOR: [*To Mrs. Dyal*] But you ask why she wouldn't feel your love. Uh—I expect that your tenderness was not as evident as your anxiousness. That this has been something harder for you to get across than your concern, so your very love takes the form of harshness as far as she experiences it.

MRS. DYAL: I think so. [*Mr. Dyal, Mrs. Dyal, Dr. Macgregor all talk at same time.*]

MR. DYAL: Well, now I've done—now I'm not smart. Don't get

me wrong. But I done seen to where they—like I said, I've had time to stop and think and start them on different angles and patterns and to show that affection to her, and show my love to her that I—I. . . .

DR. MACGREGOR: I think your task—otherwise you run into the same kind of problem, that Mother may have had less in awareness with *her* father. That your real task is to pay attention to your *wife* in such a way that *she* feels strong. It would be a mistake for you to try and supply directly the affection that daughter feels she needs. Maybe that would have been fine when she was much younger, but now it is trust that she needs, and confidence in her growing womanhood.

MR. DYAL: We can't call back the years, that I can see.

DR. MACGREGOR: This girl is *supposed* to have a crush on Daddy. That wouldn't be any problem at all. But it might interfere with her growing into womanhood if she, as her dream or her fantasy suggests, makes herself Daddy's girl, but not Mommy's girl. [*Telephone buzzer sounds—Sally and Mrs. Ritchie will return.*]

DR. SERRANO: Yes, actually, that does mean that she may need to know you as a force of love and affection rather than as a subject of anxiety. [*Inaudible, Mrs. Ritchie and Sally come in.*]

DR. MACGREGOR: Well, I must say the matters for discussion were much those that you've heard. In addition to some specific concern for the kinds of fantasies that—uh—have been, that you've had at times, like—oh—"I'm not really Mother's daughter, but I'm Daddy's daughter," and that kind of thing. You may have noticed these among your friends, too. It is a fairly common feeling that—uh—goes on at that age where one confronts Mother, one confronts concern, and Daddy seems to lead a more interesting life. I think it needs some repair work. Really, Mother's life needs to be more interesting. You get to know her better that way. [*Pause*]

DR. MACGREGOR: [*To Mrs. Ritchie and Sally*] Did you folks decide to give up on us?

MRS. RITCHIE: Oh no, not at all. I think that as we were talking

over there and this girl really can see how things were going, to make things worse and worse and worse between her and her parents. And somewhere along the way, probably coming to see Dr. W., there was a turning point, and now there is more understanding. The repair work is already under way. These fantasies are not just Sally's fantasies. She sees her mother as fantasizing her as being a perfect creature, and if she betrays anything less than the perfection that her mother has in her mind for a daughter, this is too hurtful for Mother. So therefore she tries to cover up, and her way to cover up is to lie.

DR. MACGREGOR: Well, to be as perfect as Mother, that's a pretty good model right there.

MRS. RITCHIE: Not as perfect as Mother, as perfect as Mother thinks she is.

MR. DYAL: As perfect as Mother would like for her to be, or as perfect as Daddy would like for her to be.

MRS. RITCHIE: You hit the nail on the head, yes, sir. That's what I was trying to say. You said it much better.

MR. DYAL: Well, just like I tell you, I—I—that's happened to me in the last two weeks.

MRS. RITCHIE: Uh-huh.

MR. DYAL: It's I want her to be something that I wasn't, and in turn I expected my wife to make her into the something that I could idolize, that I could be—it would be something to sit back and look at and say, "Well, I had a hand in doing that."

MRS. RITCHIE: Yes, sir.

MR. DYAL: That's where I made my mistake! And I've seen it, I—I realize it, and. . .

DR. MACGREGOR: She hasn't been too much hurt by that influence if she's still acceptable among her girl friends. Now if what you say was—uh—the whole influence, she'd be the kind of girl who would be very pleasant among the boys, but the girls wouldn't like her. And—uh—this fact that men don't know how to be young women. . .

MR. DYAL: No, but I was using my wife for her. I was putting all the responsibility on her for her to see that Sally was what I wanted.

MRS. DYAL: Actually, in trying to raise Sally I feel that I was only trying to raise her to be the right kind of person that she should be.

DR. MACGREGOR: [To Mr. Dyal] It doesn't sound like she was operating entirely as your agent.

MR. DYAL: Well, I had the feeling that she was.

MRS. DYAL: [Interrupting] And if I was doing wrong, if we're just supposed to turn them loose and let them raise themselves. . . .

MRS. RITCHIE: Does it sound like that's what we're recommending?

MRS. DYAL: No, but—uh—it seems that that's the way Sally would see the other girls at school. [Softly] Now, Sally, you can help me here, you help me. It seems that she would see them this way: that is, they'd say, "Now, Mother, I'm going here," and they'd take off and they'd go. Or, "I'm going to do this" and "I'm going to do that." And—uh—they lived a happy, normal life of course, sort of a—some of the consequences were high. Sally knows about them.

DR. MACGREGOR: It often can happen that a girl can tell her mother that she is going here or there, but it requires some building of confidence between them so that they are predictable to each other. Now I'm sure that. . . .

MRS. RITCHIE: Yes, this is something that Sally and I discussed very directly. At the point at which she was deceiving you it was impossible for you to trust her.

MRS. DYAL: That's right, it really is, it's. . . .

MRS. RITCHIE: It's really up to her to win back your trust, and she's making a valiant effort to do this, and I hope it's a successful one.

MRS. DYAL: [Interrupting] I told her time and again, and I said, "Now, Sally, Mother stands by you regardless. Now if you. . . . And she tells me, "Now I'm not going to do those things any more."

And then Sally would do the same things. But yet I wouldn't give up. I feel this way: that—uh—there's lots of good in Sally, though she did some things that wasn't pleasing me and her daddy.

MRS. RITCHIE: Sure, there's bound to be lots of good in Sally; look at her parents.

MRS. DYAL: And they certainly weren't things that she should be doing.

DR. MACGREGOR: Things would be lots easier if the old man were around to be nagged more so she'd not have to get all the nagging.

MR. DYAL: Well, that's got a lot to do with it. Me being away from home as much as I have had to be. . . .

DR. MACGREGOR: Nagging is a very important outlet for women. There are better ones that you can develop. It isn't something they do that they like to do. It's something they do because they have to. They have to get it out somehow.

MRS. RITCHIE: Yes, but this is the man's livelihood and his way of making a living, and I don't see any point in his leaving here thinking that we are recommending that he ought to give up this way of life for another way of life. This is the way you make a living and it's a good living for your family.

MR. DYAL: I changed that, I mean I changed that. A year and a half ago, and I quit boating and I worked where I told you I wanted her to take that bookkeeping job, and I worked there for eight months and. . . .

DR. MACGREGOR: Well, when you make a change, make it because it's good for you.

Mrs. Ritchie, sensing that Dr. MacGregor was indulging himself in a favorite lecture about nagging, came to Mr. Dyal's defense really to reinforce the point that to live one's life for another sets no useful example to the child. When Mr. Dyal lamented the amount of time he spent away from his family, Dr. Seranno argued that quality of relationship is more important than clock hours. With convergence Mrs. Ritchie reported:

MRS. RITCHIE: Well, we talked about this too, Sally and I. That

—uh—to convey one's feeling of love and concern and affection doesn't take a lot of time. Sally said it, not I. "It only takes a few seconds." [To Mr. Dyal] She feels that you do this now.

MR. DYAL: But if you don't stop long enough for those few seconds to convey that—I know, because I didn't stop, I took it for granted that they knew that I loved them. Now that's the whole thing. I just took it for granted, but now she ought to know I love her. I do everything I can for her. But the one thing was for me to show that love, and I didn't do it.

DR. MACGREGOR: Your wife needs this showing, too.

MR. DYAL: What do you mean?

DR. MACGREGOR: Your wife needs this too.

MR. DYAL: If anything, I have showed her every way a man can show a woman that she had my love and she—if anything, I showed her that all my love went to her and maybe none to the children. If it's possible, now she can tell you.

MRS. DYAL: Well, I think possibly that considering the troubles I had, the attention he showed me, not that he loved me and didn't love the children. Possibly too much of the attention when he *did* come home was to me and not to the children.

DR. MACGREGOR: You were actually the needier one at the time.

MR. DYAL: Well, she was sick and suffering and I thought "Now if I can console her and help her with her suffering—it'll make it easier for her and the children." Well, I was maybe showing too much to her. I can see that now, probably, and not having enough for the children, too. I mean, not just Sally, for the other two, too.

DR. MACGREGOR: [To Mrs. Dyal] Uh-huh. Do you feel awfully ashamed of having been needy in your life? Was there something you could have done about it? I doubt it.

MRS. DYAL: [Crying] But I've always felt like I didn't want to depend on anybody. Even my family, I . . .

DR. MACGREGOR: Your children won't be ashamed to ask for things for themselves if you can get over some of this shame about —uh—of needing things for yourself every now and then.

MRS. DYAL: [Interrupting] It's not that I was ashamed to ask for them. It's just that I never wanted to feel that they had to do

things for me if I could do them for myself. [*Still crying*] And I thought of L. M. . . . [*Hesitates and seems to reconsider*]

DR. MACGREGOR: Now you seem to be ashamed of neediness that you have that's based on actual historical facts. What this communicates to the kids is that they should be ashamed if they're needy.

MRS. DYAL: Well, I certainly didn't mean it that way.

DR. MACGREGOR: Or that they have to put up some kind of a front which makes them feel false.

MRS. DYAL: I just feel this way. When I was in bed, it was over three months, well, I didn't want people coming in. I didn't want them to feel that they had to do for me!

MR. DYAL: But I can see now that was the wrong feeling for her to have had.

MRS. DYAL: When L.M. was at home he did for me, and of course when he was away I just had the children.

MR. DYAL: I feel that if you have a friend, and if that friend can't help you when you need help, they're not a friend. And I tried to convey that feeling that it wasn't that they had to help—they done it because they loved us and wanted to help.

DR. MACGREGOR: Well, I think this problem is pretty well licked. Otherwise, you wouldn't be able to accept our help. I would think that we could be more helpful if—I'm proposing this to everybody—if we might look in on you again a month from now. It seems to me that you have enough going on in your life that it's not quite clear. . . .

DR. SERRANO: [*Interrupting*] I would give them more time than that. [*Pause*] Because things are going on very well, I would say. And—uh—this family emotional repair may take longer. And they need to explore more before having to think that they have to come here with some kind of a test done.

FORMULATION

According to the present stage of the development of our nomenclature for family syndromes we classify the Dyal family with "families presenting preadolescent functioning in adolescence, the

rebels." Attitudes, behavior, and patterns of family interaction which identify this diagnosis for the Dyal family are given below. The reader may wish to refer to the entry typical of this syndrome which appears in each case after the letter D in Table 7-2, Chap. 7. A further description of the behavior associated with each entry appears in Chap. 4 in the section titled "The Rebel and His Family."¹

1. *Sociodynamics*. Unable to allow others really to get to know her (fear of intimacy-identity), she substituted a generalized opposition to adult standards which, while acceptable to her peers, shocked them a bit.

2. *Age-mates*. A caricature of her age group, she was more dedicated to being with the boys and more nonchalant about adult-valued interests than most of her peers dared to be.

3. *Sex role in relation to parents*. She was provocative toward her father and competitive with her mother. Because of chronic illness and low self-esteem, the mother presented an unattractive model of adult femininity. The barrier to communication with the father seemed to provide mutual protection against libidinous material between father and daughter, as well as against excessively destructive effects of rivalry between mother and daughter.

4. *Sex role with peers*. Her behavior with boys had more to do with her need for attention and recognition than with any real interest in another person of opposite sex.

5. *Education*. Educational aptitude and ability was high, but she dared not show interest in educational progress. This was so much more her mother's project than her own that show of interest could reward her mother's possessiveness.

¹ Because most of the items in the outline, Table 7-2, are of the nature of interactions, several items have been described together in Chap. 4. For example, observations concerning item 1, "sociodynamics," item 3, "sex role in relation to parents," and item 7, "manner of dealing with anxiety," appear under several headings. Item 12, "exploitation," is described with the patterns of *mothers* and of *fathers* under "intrafamilial relations." Item 13, "value transmission," and item 16, "community relations," are treated as aspects of *communication*.

6. *Authority.* The pattern of rebellion and runaway guaranteed her attention from parents and authority that would otherwise have been lacking. Pseudo rebellion had as its goal the receiving of greater supervision and delay of freedom.

7. *Anxiety.* The anxiety which stems from the exercise of initiative and fear of the associated responsibility for the conduct of her affairs she attempted to diffuse into group responsibility. She did this by telling her family and herself that all she did and all she asked for were the rights of teen-agers generally. Anxiety was also directly relieved by rebellious acts and by the fact that they resulted in her being relieved of responsibility.

8. *Family constellation.* While Mr. Dyal blatantly claimed to be a determining influence (aggressive quadrant overt), he had been protected from much understanding of his children by his wife's covert leadership and her need to make up for her own feelings of unworthiness (aggressive quadrant covert). The adolescent occupied the quadrant of emotional instability, using unpredictability as a refuge from identity. Siblings were cooperative and somewhat subdued (passive-dependent quadrant).

9. *Siblings.* No evidence of sibling competition (until follow-up, when the sibling who specializes in obedience resisted change).

10. *Pattern of fatherhood.* The father's relationship, once close to his daughter, became remote after her puberty. He defended his role as having been specialized in providing for the family. He realized he had been excessive in his expectation that his wife rear the children according to his requirements.

11. *Pattern of motherhood.* The convalescent mother had sought paternal attention from her husband at the expense of the children, whom she pressured to meet her husband's expectations.

12. *Exploitation.* Both parents attempted to live through the child unexpressed and unattained goals from their own lives. They naively described the nominal patient as an extension of themselves.

13. *Value transmission.* Sally expressed the value transmission

by behavior for which her mother could only yearn and by behavior which recapitulated indolent aspects of her father's youth.

14. *Crisis*. The family mobilized to contain its rebellious member.

15. *Attitude toward team*. While all claimed the blame, Mr. Dyal attempted to exonerate himself morally and at the same time to show himself to be the root of all evil. Sally maintained a disdainful attitude toward team and parents in the initial phase. The mother compulsively revealed guilt feelings after a substantial effort to attribute her faults to illness.

16. *Community relations*. This family, concerned with low socioeconomic status, was ready to risk much to have a new house and respectability among neighbors.

17. *Communicative style*. All are eloquent, histrionic in expressing themselves outside the home, but rarely discuss problems with each other. School and community figures usually knew of their problems before the family had discussed them. The father was concerned about child rearing in terms of whether his friends and relatives of his generation would continue to appraise him unfavorably (collateral orientation) while the mother was oriented more to the approval of shadowy figures of the past (lineal orientation).

FOLLOW-UP

A letter two months later to arrange follow-up indicated that Mrs. Dyal was enjoying settling in a new house. She could say that the advantage of having a car instead of the truck, which had been necessary to pull a trailer, is that now she rides in comfort. She was also enjoying the new-found privacy the house provided for herself, her daughter, and other family members. She requested postponement of the two and one-half months follow-up appointment. Sally was doing well in school and it appeared she would be graduated with her high school class in June.

The six months follow-up session started with a crisis. In the final weeks of the school year it appeared to the neighborhood

and school that Sally was having a flirtation with the carpenter who had built their new home. In this relationship Sally became aware that she was misleading an unstable married man and was able to reject him. At follow-up she and her mother were able to agree that such early schoolgirl crushes were more to be treasured in memory than to be subjects of remorse. Therapy at follow-up was again largely directed toward affirming the worth of what a mother had to contribute to a daughter from her experience. In a two-hour session similar in format to the initial sessions at this clinic, the team was able to see sufficient strength in the family's handling of the crisis. The father's fury at the carpenter was acceptable to the family. Concern lest he hurt the other man's family relations in defending his errant daughter indicated improvement in his own ability to control impulses. A conference in her mother's automobile between the three women (Sally, her mother, and the carpenter's wife) occurred when Sally had been picked up at the bus station from an abortive runaway attempt. Sally's account of her ability to observe herself and to control impulses in situations that invited considerable intimacy with the carpenter showed her adolescent rebellion to be diminishing. During the follow-up visit she rejected her own plan to spend the summer with the Galveston County friends and was able to return to graduate with her class. She returned during the summer for two individual sessions with the psychiatrist. She said that instead of being shunned for her indiscretion as she had anticipated, she enjoyed slightly elevated status among her girl friends.

Diagnostically, Sally had progressed toward maturity. She was able to stay with anxiety engendered by her flirtation well enough to make her own appraisal of the man. No longer a caricature of her age group, no longer confused by veiled substitutes for parental affection, her heterosexual interests are no longer in the service of rebellion or of gaining peer-group status. She is interested in education, cooperative with authority, and confident of her individual identity. In the family constellation the mother openly accepts her leadership function and the father is released from his excesses

of superficial protectiveness to become intimately associated with the growth experiences of his wife and daughter. Thus, he no longer has to treat them as children to avoid an incest barrier. The mother does not use the handicap of illness or the children's worth to justify her husband's attentions, nor need she live vicariously through her daughter. Barriers to communication no longer require expert intervention.

APPENDIX B

Chapter Notes

Notes to Chapter 1

¹ Milton and Margaret Sullivan contacted the several family therapy projects. They found that the investigators had developed family therapy separately and rather quietly over approximately the same period of years. The surprise was that when the work was reported nobody objected very strongly. Dr. Don D. Jackson ventured that the times were ready for it. *Saturday Evening Post* vol. 235 (August 4, 1962) 46-51.

The background in hospital psychiatry referred to in our first paragraph includes the study by Joseph Abrahams and Edith Varon of schizophrenic girls and their mothers in group therapy in the late 1940s, reported in *Maternal Dependency and Schizophrenia* (New York: International Press, 1953). The "exit interview in psychodrama" is reported from the same hospital by James M. Ennis, "A Note on the Organization of the St. Elizabeth's Hospital Psychodrama Program," *Group Psychotherapy* vol. III (August-December, 1950) 253-255. Finally, we refer to the project of L. Murray Bowen which ran from 1954 to 1959, in which seven complete families were hospitalized. From this work he reports "A Family Concept of Schizophrenia," in Don D. Jackson, ed., *The Etiology of Schizophrenia* (New York: Basic Books, Inc., Publishers, 1960).

² Bronfenbrenner, Urie, and Edward C. Devereux, "Interdisciplinary Planning for Team Research on Constructive Community Behavior," *Human Relations* vol. 5 (May, 1952) 187-203.

³ Johnson, Adelaide M., "Collaborative Psychotherapy: Team Setting," in Marcel Heiman, *Psychoanalysis and Social Work* (New York: International Universities Press, Inc., 1953).

⁴ Starr, Phillip H., "The 'Triangular' Treatment Approach in Child Therapy: Complementary Psychotherapy of Mother and Child," *Am. J. Psychotherapy* vol. 10 (January, 1956) 40-53.

⁵ H. S. Sullivan's observation through the use of a specially constructed ward in which all personnel were part of a therapeutic environment, now reported in full in *Schizophrenia: A Human Process* (New York: W. W. Norton & Company, Inc., 1962), was probably the stimulus for studies reported by Alfred H. Stanton and Morris Schwartz such as "The Management of a Type of Institutional Participation in Mental Illness," *Psychiatry* vol. 12 (February, 1949) 13-26; and David McK. Rioch and Alfred H. Stanton, "Milieu Therapy," *Psychiatry* vol. 16 (February, 1953) 65-72. Multiple psychotherapy is described and compared in John Warkentin, Nan L. Johnson, and Carl A. Whitaker, "A Comparison of Individual and Multiple Psychotherapy," *Psychiatry* vol. 14 (November, 1951) 415-418. Peter A. Martin and H. Waldo Bird describe their way of collaboration through consultation in "An Approach to the Psychotherapy of Marriage Partners: The Stereoscopic Technique," *Psychiatry* vol. 16 (May, 1953) 123-127.

⁶ Jackson, Don D., and John Weakland, "Conjoint Family Therapy: Some Considerations, Theory, Technique, and Results" *Psychiatry* vol. 24 (February, 1961) 30-45.

⁷ "Multiple Contact Therapy" was the title of a 1957 grant request deferred during the pilot study and then rewritten. The history of the family-centered emphasis of the Youth Development Project appears in two pamphlets by Bert Kruger Smith, "A Quarter for Growing Up" and "A Family Grows," available from the Hogg Foundation for Mental Health, The University of Texas,

Austin, Texas. Reports of experience of staff members in the use of MIT appear in Frank P. Schuster, Jr., "Summary Description of Multiple Impact Therapy" *Texas Reports on Biology and Medicine* vol. 17 (Fall, 1959) 426-430; in Robert MacGregor, "Multiple Impact Psychotherapy with Families" *Family Process* vol. 1 (March, 1962) 15-29; and in Harold A. Goolishian, "A Brief Psychotherapy Program for Disturbed Adolescents" *Am. J. Orthopsychiat.* vol. 32 (January, 1962) 142-148.

⁸ Caplan, Gerald, "An Approach to the Study of the Family Mental Health" *Public Health Rep. (U.S.)* vol. 71 (October, 1956) 1027-1030.

⁹ Use of the term "evocative therapy" was recommended by John C. Whitehorn to a 1958 conference on research in psychotherapy as a way of expressing the goal of most analytical therapies to evoke health. "Goals of Psychotherapy" in Eli Rubenstein and Morris B. Parloff, eds., *Research in Psychotherapy* (Washington, D.C.: American Psychological Association, Inc., 1959). Jerome D. Frank explores the use of the term and the rationale of evocative therapies in *Persuasion and Healing: A Comparative Study of Psychotherapy* (Baltimore: The Johns Hopkins Press, 1961).

¹⁰ Lidz, Theodore, Alice R. Cornelison, Stephen Fleck, and Dorothy Terry, "The Intrafamilial Environment of Schizophrenic Patients: II, Marital Schism and Marital Skew," *Am. J. Psychiat.* vol. 114 (September, 1957) 241-248.

¹¹ Jackson, Don D., "The Question of Family Homeostasis," *Psychiat. Quart.* vol. 13 (Supplement 1957) 79-90.

¹² Wynne, Lyman, Irving Ryckoff, Juliana Day, and Stanley Hirsch, "Pseudomutuality in the Family Relations of Schizophrenia," *Psychiatry* vol. 21 (August, 1958) 205-220.

¹³ Bertalanffy, Ludwig von, "Some Biological Considerations of the Problem of Mental Illness," in Lawrence Appleby, Jordan M. Scher, and John Cummings, eds., *Chronic Schizophrenia* (New York: The Free Press of Glencoe, 1960) pp. 36-53, 341.

¹⁴ Bell, John E., *Family Group Therapy* (Public Health Mono-

graph 64, Washington, D.C.: U.S. Department of Health, Education, and Welfare, 1961).

¹⁵ Ackerman, Nathan W., *The Psychodynamics of Family Life: Diagnosis and Treatment of Family Relationships* (New York: Basic Books, Inc., Publishers, 1958).

¹⁶ The conference report cited in note 9 deals with some of the methodological problems. For a more humorous view of research that sets out to study psychotherapy and instead reports on methodology and types of people see Alexander W. Astin, "The Functional Autonomy of Psychotherapy," *Amer. Psychologist* vol. 16 (February, 1961) 75-78.

¹⁷ Earl S. Schaefer cites several investigators—Erica Chance, 1959; Percival Symond, 1939; Anne Roe, 1957; and Schaefer, 1959—whose studies were expressed in two-dimensional charts, the quadrants of which are similar although their research was unrelated in method and type of data. "Converging Conceptual Models for Maternal Behavior and Child Behavior" in John C. Glidewell, ed., *Parental Attitudes and Child Behavior* (Springfield, Ill.: Charles C Thomas, 1961).

Notes to Chapter 2

¹ Children or adolescent patients who had been too much the center and focus of the family were sometimes relegated to the waiting room for an hour or more. This "wholesome neglect" was intended to be therapeutic, and to symbolize the team's interest, concern, and respect for the adults of the family.

² Note that Dr. Serrano, a basic team member, exerts a corrective influence on both the resident and Peter, by helping them to understand rather than condemn the parents. It may be of interest as evidence of the training possibilities to note the several instances in which the resident's hostility was obvious, and his attitude then became more therapeutic as he followed the lead of more experienced therapists. In the tape recording of this session the change in the tone of voice makes it dramatically clear that the resident was following the lead of the staff psychiatrist.

Notes to Chapter 3

¹ The overlapping interview was first described by Agnes Ritchie in "Multiple Impact Therapy: An Experiment," *Social Work* vol. 5 (July, 1960) 16-21.

² The family has already been given to understand that some of the content of private sessions, other than that which they definitely label as secret, may be shared with other family members. The neurotic aspect of excessive secrecy is dealt with from the viewpoint expressed by Nathan Ackerman in the introduction to his book, *The Psychodynamics of Family Life* (New York: Basic Books, Inc., Publishers, 1958).

³ The concept of the "well sibling" applies better to the families that brought more childish and schizophrenic nominal patients. Juliana Day, Lyman C. Wynne, Leslie Schaffer, et al., "The Psychiatric 'Patient' and His 'Well' Sibling," presented at the annual meeting of the American Psychiatric Association, Atlantic City, May, 1960.

⁴ Clinics adopting our methods find it satisfactory to start with their own dictation outline or with one from a standard examination form. It is important that the outline always be in a stage of development. Its headings reflect clinical experience in presenting case material vividly. Following is the outline that was developed for summary reports on families included in this study.

Dictation Outline for Multiple Impact Therapy

Subject: (nominal patient and family name)

Date of MIT: _____

Date of Screening: _____

For the Family: (names and ages of family members participating, and name and title of any community representative)

For YDP: (names and disciplines of team members)

Referral: (date, source, and reason for referral)

Complaint Picture: (includes complaints reported by referring person, parents, nominal patient and siblings, as well as brief comment on additional problems seen by team)

Crisis: (which precipitated application or referral)

Appearance and Attitude of the Family: (general description of relationships between family members supplemented by four-fold chart of reciprocal immaturity reactions—aggressive, passive-aggressive, passive-dependent, emotionally unstable)

Living Situation: (neighborhood, type of home, sleeping arrangements, etc.)

Sibling Situations (more detailed report on relationships)

Father's Interpersonal Pattern: (patterns of fatherhood in this family:

A. father's background and history

B. father's current functioning)

Mother's Interpersonal Pattern: (as above)

Exploitation: (who is using or exploiting whom in family, and how)

Nominal Patient's Interpersonal Pattern:

Age-typical, Role-typical Behavior: (sometimes separated into two sections; peer relationships and opposite-sex relationships)

Relation to Authority: (re adolescent and, where appropriate, other family members or the family as a whole)

Education: (status, attitude, and prognosis; re adolescent and also other family members when significant)

Occupation: (as above)

Communication: (quality and quantity within the family)

Value Transmission: (include discrepancy between overt and covert value system of parents)

Anxiety: (manner of expression and method of handling by nominal patient)

Community Relations: (amount and quality of involvement)

Alternate or Supplementary Therapy: (recommendations for hospitalization, continuing individual or group therapy, medication, placement, etc.)

Rehabilitative Processes: (estimate of extent to which they seem to have been mobilized)

Disposition: (plan for follow-up, or for referral elsewhere, etc.)

Fee and Plan for Payment: (relevant observations on handling of this executive function in the family)

For research purposes, the dictation outline provides places for data referable to research hypotheses. Each heading reminds the investigators to record data that might not seem germane to a particular case, but for which all cases are being checked. It is important that data be presented in such a way as to facilitate comparison of cases on a large number of attributes. Each paragraph of dictation concludes with one or more ratings for which the paragraph has the supporting data. These ratings are made on the basis of a five-point scale indicating degree of remoteness from an optimal state of affairs.

For purposes of identifying various patterns of interaction, at first names of families are sufficient, "like the Jones case," until recurring themes or patterns begin to emerge. As the four types of family constellations described in Chap. 4 were identified and defined, each topic on the dictation outline was further analyzed according to the characteristics of each type.

Notes to Chapter 4

¹ Serrano, A. C., E. C. McDanald, Jr., et al., "Adolescent Maladjustment and Family Dynamics," *Am. J. Psychiat.* vol. 118 (April, 1962) 897-901.

² Stages in the development of potentialities which may be manifested in interpersonal fields:

1. *Infancy:* extends to the maturation of the capacity to use language

2. *Childhood:* extends to the maturation of the capacity for living with compeers

3. *Juvenile era:* extends to the maturation of the capacity for isophilic intimacy

4. *Preadolescence*: extends to the maturation of the genital lust dynamism

5. *Early adolescence*: extends to the patterning of lustful behavior

6. *Late adolescence*: extends to maturity

Sullivan, H. S., "The Meaning of Anxiety in Psychiatry and in Life," *Psychiatry* vol. 11 (February, 1948) 5.

³ Erikson, E. H., "Identity and the Life Cycle," *Psychological Issues* vol. 1 (Monograph 1, 1959). (Used by permission of the editor and the publisher.)

"The claim advanced here concerns a whole series of criteria of psychosocial health which find their specific elaboration and relative completion in stages of development preceding and following the 'Identity Crisis,'" p. 119. (The following are abstracted from two columns from Erikson's "worksheet," p. 166. The titles for the stages are those assigned these same Roman numerals on p. 120.)

	Stage	A	E
I.	<i>Infancy</i>	Trust vs. Mistrust	(Incorporative modes)
II.	<i>Early Childhood</i>	Autonomy vs. Shame, Doubt	(Retentive, eliminative)
III.	<i>Play Age</i>	Initiative vs. Guilt	(Intrusive)
IV.	<i>School Age</i>	Industry vs. Inferiority	"Latency"
V.	<i>Adolescence</i>	Identity and Repudiation vs. Identity Diffusion	Puberty
VI.	<i>Young Adult</i>	Intimacy and Solidarity vs. Isolation	Genitality
VII.	<i>Adulthood</i>	Generativity vs. Self-absorption	
VIII.	<i>Mature Age</i>	Integrity vs. Disgust, Despair	

In the MIT study, failure at the task indicated by the first word in Erikson's column A is associated with arrest at that stage

of functioning. Fear of the task at the next stage appears also to be a factor with the rebel's "preadolescent functioning in adolescence." The group we have labeled "juvenile functioning in adolescence" comprehends both Erikson's stages III and IV.

⁴ Bordua, David J., "Sociological Theories and Their Implications," *Juvenile Delinquency Facts and Facets*, Report no. 2, U.S. Department of Health, Education, and Welfare, Children's Bureau, 1960.

⁵ Bowen, Murray, "A Family Concept of Schizophrenia," in Don D. Jackson, ed., *The Etiology of Schizophrenia* (New York: Basic Books, Inc., Publishers, 1960) p. 370.

⁶ Henry, Andrew F., "Sibling Structure and Perception of the Disciplinary Roles of Parents," *Sociometry* vol. 20 (1957) 67-74.

⁷ Vogel, E. F., and N. W. Bell, "The Emotionally Disturbed Child as a Family Scapegoat," in Norman W. Bell and Ezra F. Vogel, eds., *A Modern Introduction to the Family* (New York: The Free Press of Glencoe, 1960) pp. 382-397.

⁸ Lindt, Hendrik, and A. S. Goldman, "A Study of 'Special Pressures' and Their Impact on the Relationship between Mothers and Their Asthmatic Children," *Texas Reports on Biology and Medicine* vol. 19 (Summer, 1961) 300-320.

⁹ Jenkins, describing "the pseudo social child" differentiates him from the "unsocialized aggressive" in some respects, much as the rebel differs from the autocrat. "These differences are related to the fact that he is socialized in his own group and loyal to his comrades. This boy is also deceptive and defiant toward authority. When possible he avoids self-incrimination by not accepting the blame for his own acts. . . ." R. L. Jenkins, "A Psychiatric View of Personality Structure in Children," reprinted from *Delinquency and the Community in Wartime* (New York, National Probation Association, 1943 Yearbook).

¹⁰ Johnson, Adelaide M., "Sanctions for Superego Lacunae of Adolescents," in K. R. Eissler, ed., *Searchlights on Delinquency* (New York: International Universities Press, Inc., 1949) pp. 225-245.

¹¹ Frank, Jerome D., Joseph Margolin, et al., "Two Behavior Patterns in Therapeutic Groups and their Apparent Motivation," *Human Relations* vol. V (1952) 289-317.

¹² The concept developed by J. Day, L. L. Wynn, et al. of the "well sibling" applies better to the families that brought more childish and schizophrenic nominal patients, and is illustrated in the families of the autocrat. Reference note 3 to Chap. 3.

¹³ Bateson, G., D. D. Jackson, J. Haley, and J. H. Weakland, "Toward a Theory of Schizophrenia," *Behavioral Sci.* vol. 1 (1956) 251-264.

¹⁴ Bergler, E., *The Basic Neurosis* (New York: Grune & Stratton, Inc., 1949).

¹⁵ Mullahey, P., *Oedipus: Myth and Complex* (New York: Hermitage House, Inc., 1948), p. 303, discusses the developmental tasks which Sullivan assigns to childhood.

¹⁶ See for example Jackson, D. D., ed., *The Etiology of Schizophrenia* (New York: Basic Books, Inc., Publishers, 1960).

¹⁷ This was one of only four divorces subsequent to treatment in our study, one in each type of family.

Notes to Chapter 5

¹ Cassirer, E., *Language and Myth* (New York: Harper & Row, Publishers, Incorporated, 1946).

² Thomas S. Szasz, reviewing Grotjahn's *Psychoanalysis and the Family Neurosis*, regards the pro-family orientation as naïve in view of the decline of the power of the family as an institution. *Contemporary Psychology* (April, 1961) 118.

³ Andry, R., *Delinquency and Parental Pathology* (Springfield, Ill.: Charles C Thomas, Publisher, 1960).

⁴ Bowlby, J., *Maternal care and Mental Health* (Geneva: World Health Organization, 1952).

⁵ Freud, S., *Collected Papers* vol. V (London: The Hogarth Press, Ltd., 1952). In this brief article Freud shows something of the self-rehabilitating function of growth in relation to the supply of growth-enhancing material natural to families. He also differenti-

ates early and later developmental stages in "the neurotic family romance."

⁶ Kropotkin, P., *Mutual Aid: A Factor in Evolution* (New York: McClure Phillips and Co., 1902).

⁷ Reference note 3 to Chap. 3.

⁸ "From my observations of multiple impact therapy with family and team, I would agree that psychodrama may be utilized to extend the range of techniques and thereby improve the efficacy of this short term method. It seems to me that the method of dividing up interviews and then re-grouping is very much like using Dr. Moreno's technique of auxiliary-egos. It would seem likely that training in the concepts of the use of the auxiliary-ego and doubling could enhance current usage and, in addition, increasing attention to the act dimensions of behavior, broadens diagnostic and therapeutic horizons. Training in psychodrama helps focus on the non-verbal.

"The Auxiliary-Ego, Doubling, and Mirroring: As I described to you in our conversation, Dr. Moreno has written a monograph in which he described family therapy with a marital problem. At first he saw the wife alone, and then when he would see the husband, he would present the wife. In turn, when he saw the wife again, he would present the husband's view. As he developed the method, he utilized auxiliary-egos or assistant therapists who could identify with the husband or the wife. The next step was to see the wife with the auxiliary-ego of the husband. The assistant therapist, taking the role of the husband, could help the wife explore her relationship without the immediate threat or emotionality that direct confrontation with the husband would have provided. Similarly, the husband would be meeting with the therapist and auxiliary-ego of his wife. Still later, both real parties would be brought together with their assistant therapists. Now real husband and wife faced each other but had support and assistance from the people who had taken their parts. Here the prime therapist is the neutral and objective party.

"It seems to me in MIT the individual interviewers could later

become doubles and auxiliary-egos when all re-group for the general meeting. This does not mean that the system would be used all of the time, but rather, that an added technique would be available for judicious application. And too, the individual interviewer could, when the need arose, be a 'mirror' of his patient in that he could be asked to *show* as well as tell about their inter-action. Here the patient sits back and watches himself in action as portrayed by his 'mirror.' Perhaps the most important thing that we could teach is that *show me* may be as important a question as *tell me*." Leon Fine, psychodramatist, St. Louis State Hospital (personal communication).

⁹ Sullivan, H. S., *The Psychiatric Interview* (New York: W. W. Norton & Company, 1954) e.g., pp. 226-229.

¹⁰ Martin, Peter A., and H. Waldo Bird, reference note 5 to Chap. 1.

Notes to Chapter 6

¹ In the earlier days of psychotherapy research, results of psychotherapy have been claimed to accrue from adherence to theory alone (e.g., Freudian) or method alone (e.g., nondirective), H. H. Strupp, "Some Comments on the Future of Research in Psychotherapy," *Behavioral Science* (1960) 60-71. Other studies have shown that outcome may be attributed to the personality of the therapist, M. B. Parloff, "Some Factors Affecting the Quality of Therapeutic Relationships," *J. Abnormal Social Psychol.* (1956, 52) 5-10. Placebo studies have suggested that some patients got well almost without regard to these factors, D. Rosenthal and J. D. Frank, "Psychotherapy and the Placebo Effect," *Psychol. Bull.* (1956, 63) 294-302.

² Hallowitz, David, and Albert Cutter, "The Family-unit Approach in Therapy: Uses, Process, and Dynamics," 44-57; Harold A. Goolishian and Agnes Ritchie, "Multiple-impact Therapy," 31-43, *Casework Papers* 1961, New York: Family Service Association of America.

³ Charen, Sol, et al., "The Use of the Family Approach in

Working with Children in Seriously Disturbed Families," *J. Am. Acad. of Child Psychol.* (1962) 462-476. Frank is a good example of one who emphasized study of the faith of the patient in the doctor. J. D. Frank, *Perusasion and Healing: A Comparative Study of Psychotherapy* (Baltimore: The Johns Hopkins Press, 1961).

⁴ Whitaker, Carl A., John Warkentin, and Nan L. Johnson, "A Philosophical Basis for Brief Psychotherapy," *Psychiat. Quart.* vol. 23 (1949) 439-443.

⁵ The problem of a therapist or team member overidentifying with a patient and becoming hostile or punitive toward other family members or their therapists is less likely to occur with experienced, professionally mature therapists. The article by Brodey and Hayden was based on a study of two-member teams; while not explicitly stated, apparently at least one member of each team was a trainee. Warren M. Brodey and Marjorie Hayden, "Intrateam Reactions: Their Relation to the Conflicts of the Family in Treatment," *Am. J. Orthopsychiat.* vol. 27 (1957) 349-355.

⁶ Gluckman, Robert M., "The Chaplain as a Member of the Diagnostic Clinical Team," *Mental Health* (April, 1953) 37.

⁷ The Multiple Impact Therapy Project Staff wishes to acknowledge the contribution of the following people and staffs of institutions who participated in the treatment cases and gave us the benefit of their consultation: Dr. Gregory Bateson, Dr. Scott Briar, Mr. Thomas E. Garnett, Jr., Dr. Martin Grotjahn, Dr. Dale Johnson, Dr. Lester M. Libo, Dr. Stanley E. Linquist, Dr. Maurice Lorr, Dr. Roger Moon, Dr. Florence B. Powdermaker, and Dr. Melvin P. Reid; Dr. Felix Bambace and the staff of the San Antonio State Hospital Outpatient Clinic; Dr. Ann Nell Boelsche and the staff of the Child Development Clinic, University of Texas Medical Branch Pediatrics Department; Dr. George Constant and staff members of the Devereaux School of Victoria, Texas; Dr. Irvin A. Kraft and the Child Clinic staff of the Houston State Psychiatric Institution; Dr. Adolfo Rizzo and the staff of the Adolescent Service of St. Louis State Hospital.

⁸ Herzog, Elizabeth, *Some Guide Lines for Evaluative Research* (Washington: Children's Bureau Publication, U.S. Department of Health, Education, and Welfare, 1959).

Notes to Chapter 7

¹ Schuster, Franklin P., Jr., unpublished material including rating scale and scoring methods (mimeographed), and paper, "Emotional Immaturity and Family Psychopathology."

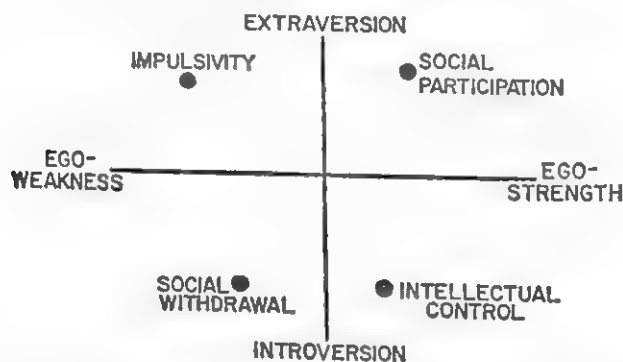


FIG. I. Kassebaum, Couch, and Slater's Model for Personality. (From Earl S. Schaefer, "Converging Conceptual Models for Maternal Behavior and for Child Behavior," in John C. Glidewell, ed., *Parental Attitudes and Child Behavior*, 1961, p. 136. Courtesy of Charles C Thomas, Publisher, Springfield, Ill.)

² In Fig. I is reproduced "a conceptual model derived by Kassebaum, Couch, and Slater (1959) from a factor analysis of data from college students on thirty-two scales of the MMPI. . . . They hypothesized that their two-dimensional structure could be replicated in any major factorial study of the personality. The model does appear similar to the organization of ratings of social and emotional behavior that are given below." From Earl S. Schaefer, "Converging Conceptual Models for Maternal Behavior and for Child Behavior," in John C. Glidewell, ed., *Parental Attitudes and Child Behavior*, 1961, pp. 136 and 137. Courtesy of Charles C Thomas, Publisher, Springfield, Ill. Schaefer then illustrates the

point by abstracting two studies. In one of these studies, which is by Richards and Simons, leadership is located in the upper right quadrant. G. G. Kassebaum, A. J. Couch, and P. E. Slater, "The Factorial Dimensions of the MMPI," *J. Consult. Psychol.* vol. 23 (1959) 226-236. T. W. Richards and Marjorie P. Simons, "The Fels Child Behavior Scales," *Genet. Psychol. Monogr.* vol. 24 (1941) 259-309.

A more recent circular ordering of attributes is presented by Maurice Lorr and Douglas M. McNair based on ratings of manifest behavior. They were able to support the earlier more intuitive circular ordering of attributes presented by Timothy Leary in *The Interpersonal Diagnosis of Personality* (New York: The Ronald Press Company, 1957). "Three similar overlapping higher order factors, Dominance, Affiliativeness versus Detachment, and Compliant Abasement, accounted for the correlation in each matrix" indicates the similarity to our own clinically derived quadrants, *J. Abnormal Social Psychol.* vol. 67 (1963) 68-75.

³ Reference note 5 to Chap. 4.

⁴ Voiland, Alice L., and Bradley Buell, "A Classification of Disordered Family Types," *Social Work* vol. 6 (October, 1961) 3-11.

⁵ Bell, John E., *Family Group Therapy*, Public Health Monograph 64 (Washington, D.C.: U.S. Department of Health, Education, and Welfare, 1962).

⁶ Jackson, D. D., and J. H. Weakland, "Conjoint Family Therapy: Some Considerations on Theory, Technique, and Results," *Psychiatry* vol. 24 (February, 1961) 30-45.

⁷ Kluckhohn, Florence R., "Variations in Basic Values of Family Systems," *Social Casework* vol. 39 (February, 1958) 63-72.

⁸ MacGregor, Robert, "Developmental Considerations in Psychotherapy with Children and Youth," presented at the annual meeting of the American Psychological Association, St. Louis, September, 1962.

⁹ Fromm, Erich, "Selfishness and Self-love," *Psychiatry* vol. 2 (November, 1939) 507-523.

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